University of Alberta

Clinical Teaching in Pakistan: The Hard Reality for Nursing Education

by

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Abstract

Clinical teaching is central to nursing education (Castledine, 2003; Morgan, 1991); it plays an important role in enabling students to learn to become nurses (Cansentino, 2003). Clinical learning is complex in nature and requires the integration of knowledge and skills into practice (Diekelmann, 1990; Karuhije, 1997; Scanlan, 1996). Changes in the health care system mean that nursing educators face new challenges in preparing nurses for the future. These challenges are related to ensuring that students acquire up-to-date and evidence-based knowledge, that they develop the ability to be independent lifelong learners, and that they develop attitudes and psychomotor skills necessary for the professional practice of nursing (Hermann, 1997).

This study was the first of its nature to be conducted in Pakistan. It explored clinical nurse teachers' and nursing students' perceptions of "clinical teaching" in that country. Data were collected with participants from three institutions (two government hospitals and one private hospital). In total, 60 semistructured interviews were conducted with clinical nurse teachers and nursing students. This study sheds light on current practices in nursing clinical teaching in Pakistan and thus brings to the forefront issues that should be addressed, or at least further examined, by schools of nursing and the nursing profession.

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Table of Contents

CHAPTER ONE: INTRODUCTION 1

Background: Pakistan 2
Population of Pakistan 3
Ethnic Groups 4
    Punjabis 4
    Pakhtuns 5
    Sindhis 5
    Muhajir 6
    Baloch 6
Language in Pakistan 7
Government in Pakistan 8
Religion in Pakistan 8
Islam and Women 9
The *Purdah* System 10
Role of Education in Women's Empowerment in Pakistan 11
Nursing 13
    Nightingale's Influence on Nursing 15
    The Nursing Profession in Pakistan 16
Healthcare Politics in Pakistan 18
Cultural Influences on Nursing 19
The Image of Nursing in Pakistan 20
Governing Bodies of Nursing in Pakistan 21
    Pakistan Nursing Council 23
    The Pakistan Nurses Federation 24
The Nursing Educational System in Pakistan 25
Role of the Aga Khan Foundation 26
Curriculum 28
Health Care Facilities in Karachi, Pakistan 29
Significance of the Proposed Study 30
Problem Statement 33
Definition of Terms 34
Objectives of the Study 35
Conclusion 37

CHAPTER TWO: LITERATURE REVIEW 38

Literature Search 38
Clinical Education 40
Definition: Clinical Supervision and Clinical Teaching 43
Historical Perspective on Clinical Practice in Nursing Education 45
Models of Clinical Teaching 48
    The Clinical Teacher Model 49
    The Preceptorship Model 50

Combination of the Clinical Teacher and Preceptorship Model 53
The Clinical Teacher 54
Knowledge and Clinical Competence 55
Teaching Skills 58
Relationship With Students 64
The Process of Clinical Teaching 67
Components of Clinical Teaching 68
Assessment 68
Observation 73
Planning Clinical Learning Activities 75
Evaluating Clinical Learning and Performance 76
Rating Scale 81
Checklists 81
Anecdotal Records 81
Written Assignments 82
Clinical Examination 86
Clinical Grading 88
Stress Associated With the Clinical Experience 89
Clinical Placement 91
Conclusion 92

CHAPTER THREE: RESEARCH METHOD 94

Study Design 94
Setting 95
Sample 96
Approval From the Institutions 97
Private Institution 97
Government Institutions 98
Use of Field Notes 99
Selection of Participants 99
Selection of the Faculty Members 99
Selection of the Nursing Students 100
Ethical Considerations 101
Data Collection 102
Interviewing Process 102
Assessment of Qualitative Data 105
Data Analysis 106
Organization of the Data 108
Conclusion 108

CHAPTER FOUR: FINDINGS FROM THE FACULTY MEMBERS 110

Profile of the Sample: Nursing Faculty 110
Clinical Teaching 113
Clinical Teaching as a Continuous Process 114
Complexity of Clinical Teaching 115

  - Competence in Clinical Teaching 116
  - Holistic Approach 117
  - Significance of Clinical Teaching in Pakistan 117
- Views on Teaching and Learning 118
  - Learning as a Lifelong Process 119
  - Environment 120
  - Facilitation 120
- Models of Clinical Teaching 121
  - Trio Model 122
  - New Approach 124
  - Traditional Approach 125
  - Haphazard Approach 125
- Characteristics of a Clinical Teacher 127
  - Knowledgeable and Skilful 127
  - Able to Motivate 130
  - Able to Role Model 131
  - Readiness to Learn 132
  - Humanistic Attributes 132
  - Self-Directed 133
- Comfort Level 134
- Clinical Experience and Content Expertise 136
  - Knowledge and Experience 137
- Teaching and Learning Strategies 140
  - Innovation 140
  - Peers 142
  - Discussion 143
  - Demonstration 143
  - Pre- and Postconferences 144
  - Doctors' Rounds 145
  - Nursing Process 145
- Written Assignments 146
  - Concept Mapping 150
  - Reflections 151
- Pre- and Postconferences 151
- Clinical Evaluation 155
  - Private Institution 156
  - Timely Evaluation 158
  - Strategies for Evaluation 158
  - Grading 159
- Clinical Placements 162
  - Private Institution 162
  - Government Institution 165

Stressors 166
  Student-to-Faculty Ratio 167
  Workload 168
  Evaluation 170
  Administrative Roles 171
  Lack of Resources 172
  Gender Issues 173
  Safety 174
Influence of Culture on Nursing 175
  Perception 176
  Higher Education 178
  Men in Nursing 179
Theory-Practice Gap 180
Continuing Education 182
Clinical Teaching in Pakistan 186
  Collaboration Between Service and Education 186
  Government Organization/Limited Resources 187
  Curriculum 188
  Facilitation 189
  Recognition 190
Conclusion 190

CHAPTER FIVE: FINDINGS FROM THE NURSING STUDENTS 192

Profile of the Sample: Nursing Students 192
Clinical Teaching 193
Narrative Analysis From the Private Institution 194
Characteristics of the Clinical Teacher 197
  Knowledgeable 197
  Humanistic 199
  Ability to Role Model 201
Clinical Experience 202
  Government Institutions 202
  Private Institution 204
Teaching and Learning Strategies 206
  Government Institutions 206
  Private Institution 207
Written Assignments 209
  Government Institutions 209
  Private Institution 210
Pre- and Postconferences 212
  Government Institution 213
  Private Institution 213
Clinical Evaluation 215
  Government Institution 215
  Private Institution 217

Stressors 218
    Government Institutions 219
    Private Institution 220
Culture 222
    Government Institutions 222
    Private Institution 223
Clinical Teaching in Pakistan 225
    Government Institutions 225
    Private Institution 227

CHAPTER SIX: DISCUSSION 229

Research Question 1 231
    Models of Clinical Teaching 234
    Teaching and Learning Strategies 236
Research Question 2 242
Research Question 3 244
Research Question 4 247
Research Question 5 249
Research Question 6 251
Limitations of the Study 251
Challenges in Implementing the suggestions 252
Two Emerging Priorities 253
Implications of the Study for Nursing 256
    Nursing Education 257
    Nursing Administration 258
    Nursing Research 259

REFERENCES 262

APPENDIX A: A SUMMARY OF THE SAMPLING 282

APPENDIX B: INFORMATION LETTER: ENGLISH AND URDU 284

APPENDIX C: CONSENT FORM: ENGLISH AND URDU 293

APPENDIX D: ETHICS APPROVAL 296

APPENDIX E: ACCESS TO THE PARTICIPANTS 301

APPENDIX F: SEMISTRUCTURED INTERVIEW GUIDES 302

List of Tables

Table 1. Demographic Data of the Nursing Faculty 111

Table 2. Level of Education of Nursing Faculty 112

Table 3. Clinical Experience of Faculty Members Prior to Teaching 112

Table 4. Teaching Experience of Nursing Faculty 113

Table 5. Themes That Emerged on Clinical Teaching 114

Table 6. Themes That Emerged on Education 119

Table 7. Clinical Teaching Models 122

Table 8. Themes That Emerged on the Characteristics of Clinical Teachers 127

Table 9. Themes That Emerged on Teaching and Learning Strategies 140

Table 10. Written Assignments 147

Table 11. Themes That Emerged on Evaluation 155

Table 12. Themes That Emerged on Stressors in Clinical Teaching 166

Table 13. Themes That Emerged on Influence of Culture on Nursing 176

Table 14. Continuing Education 185

List of Figures

Figure 1. The Concept of Clinical Teaching in Pakistan. 242

Figure 2. The Preparation of a Clinical Teacher. 254

Figure 3. The Factors Influencing Clinical teaching. 255

Figure 4. The Procedures and Implications of Evaluation. 256

CHAPTER ONE:

INTRODUCTION

This thesis is divided into six chapters. Chapter one provides the context of the study, followed by the research questions. Chapter Two presents a literature review on the topic of clinical nursing education. Chapter Three describes the study design and the ethical process followed for the study. Chapter Four includes the findings from the data that I collected from the faculty members of the three institutions in the province of Sindh. I asked 16 questions and analyzed the responses accordingly. Chapter Five presents the analysis of the data from the 10 questions that I gathered from the nursing students in the three years of the diploma program at the three institutions. Chapter Six includes the discussion of the findings.

As mentioned, chapter one provides the context necessary to introduce the research topic of clinical teaching in Pakistan. It begins with a brief description of Pakistan as a multicultural country. One might question how Pakistan's multicultural society impacts on nursing in the country. This question becomes even more complex considering the Pakistani context. The sections on cultural influences on nursing—in particular, the role of Islam, the attitudes towards women, and the image of nursing—provide some insight into this issue. A large portion of the chapter is devoted to nursing in Pakistan, followed by an overview of Pakistan's nursing education system, with a focus on the learners' (nursing students') ethnic and religious backgrounds, the facilitators' (nursing teachers') educational philosophies, and the context in which the education is delivered (the types of health care institutions).

Nursing in Pakistan is greatly influenced by the contribution of the Aga Khan University (AKU) Medical Center (AKUMC). The Aga Khan School of Nursing (AKUSON) was inaugurated in 1981 by President General Zia ul-Haq; its primary objective was to raise the standards of nursing in the country by recognizing the importance of nursing and encouraging young women to enroll in this respected and dignified profession.

What influenced my decision to select clinical teaching in Pakistan as a research topic? One of the concerns was the development of competence of the nursing students in the clinical area, which is a problem not only in Pakistan, but also in developed countries. *Competence* means the ability to perform practical skills safely with reference to standard criteria. This is a complex phenomenon to explore because it involves numerous variables that influence the outcomes of nursing students' performance. Some of these are the type of placement or facility, clinical teachers' knowledge and skills, and nursing students' motives regarding the profession. The problem becomes even more difficult to study in a place such as Pakistan where traditional customs and values are to be respected at all times. A literature search on the topic revealed limited information on current clinical teaching in Pakistan.

Background: Pakistan

The Islamic Republic of Pakistan is the 34th largest nation in the world. It is situated in the northwest part of South Asia, surrounded by Iran to the west, Afghanistan to the north, China to the northeast, India to the east, and the Arabian Sea to the south east. This section highlights the significant features of Karachi in Sindh province, which was the site for data collection. Karachi, Pakistan's largest and most rapidly growing city, expanded rapidly because of seaport and railway connections, which resulted in massive irrigation projects and agricultural exports. Karachi's rapid growth has affected the overall economic growth of the country. At the time of the partition of Indo-Pakistan, Pakistan promoted an influx of Muslim merchants. Initially, Karachi developed in isolation; few people from outside areas were engaged in employment. But when the economics of southern Sindh began to expand, large numbers of migrants flooded into the city looking for work, and with this Karachi became the center of the nation's commerce. However, the city has recently faced serious political problems that have affected the overall economic growth of the country (Country Studies US, 2005f).

Population of Pakistan

Pakistan's population was expected to reach 150 million by 2000. It had an annual growth rate of 2.8% and a fertility rate of 5.1% in 2002 (UNICEF, 2002). The majority of the population lives in urban settings because of better living standards (World Bank, 2000), which refers to basic human needs such as employment opportunities, access to health care, transportation, and the communication system. For example, rural areas generally have one health clinic in each locality with one lady health visitor who is responsible for 10,000 people. Roads are not constructed, and pathways are narrow, making it difficult to drive motor vehicles. This means, for example, that if a woman is in labor in the rural area, family members have to carry her to the clinic on a bed, and it may take two to four hours to reach the clinic before she receives medical attention. Even though slums are found in major cities, the better living conditions in cities compared to rural areas encourage people to settle in urban areas. Only 15.68% of Pakistan's population still lives in rural areas.

The basic indicators of a country tell a great deal about the country's planning and priorities in different sectors. These indicators include information about demographic status, education level, and prevailing health conditions. Data from UNICEF (2002) indicate that the annual number of deaths under age five was 579 per 1,000, and the maternal mortality rate from 1985 to 2002 was 530 per 1,000. The gross national income (GNI) per capita was US$410, and the total adult literacy rate was 43%. The estimated number of people living with HIV/AIDS in Pakistan between the ages 0 and 49 years is 78,000 (UNICEF, 2002).

Ethnic Groups

The population of Pakistan is divided into five major ethnic groups: Punjabis (59.1%), Pakhtuns (13.8%), Sindhi (12.1%), Baloch (4.3%), Muhajirs (7.7%), and other ethnic groups (3%). These ethnic groups reside in four provinces: Punjab, North-West Frontier Province, Sindh, and Baluchistan. Each ethnic group is concentrated primarily in its own province, with the exception that most Muhajirs reside in urban Sindh (Exploitz.com, 2004). In addition, three million Afghan refugees have settled in the country. Therefore, Pakistan is considered a "multicultural community" with distinct ethnic and religious organizations. A brief overview of the five major ethnic groups including the historical background and cultural beliefs that influence their lifestyle is presented below.

Punjabis

Most Punjabis belong to the ancestry of the pre-Islamic Jat and Rajput castes. An imperative feature of the Punjabi ethnicity is reciprocity at the village level. A man's brother is his friend, his friend is his brother, and both enjoy equal access to his resources. Punjabis predominate in the military and civil service. Of the three prominent national politicians in the 1980s and early 1990s, two were Punjabis: President Zia ul-Haq and Prime Minister Mian Nawaz Sharif (Country Studies US, 2005f).

Pakhtuns

The North-West Frontier Province is comprised of Pakhtuns, one of the largest tribal groups in the world. Pakhtuns adhere to the male-centered code of conduct, the *pakhtunwali*, which signifies the notion of honor and *nang*.[1] Without honor, life for Pakhtuns is not worth living. Honor demands the maintenance of sexual propriety and complete chastity among female relatives; only with the purity and good repute of his mother, daughter, and wife (wives) does a man ensure his honor. Thus, women are restricted from the outside world and confined to their homes. Closely related to the notion of honor is the principle of revenge, or *badal.*[2] Although minor problems can be settled by negotiation, Pakhtuns turn to revenge and killing. In this culture the man's greatest rival is for women (*Zan*), money (*Zar*) and land (*Zaman)* (Country Studies US, 2005e).

Sindhis

During British rule the Sindhi community was situated in south Punjab; after independence in 1947 they moved to northeast Karachi. The Sindhi society was dominated by a small number of major landholders (*waderas*). Most people were tenant farmers who were suffering from poverty and feudal landlords' rule. However, those who migrated to big cities adopted the urban lifestyle. During the 1980s there were issues of kidnapping in the province, and it is thought that those kidnapped were associated with political influences in the country. Thus, during the 1980s interior Sindh became an unsafe area for traveling, especially for foreigners. Until 1994 foreigners were not allowed to travel in areas such as Thatta (Country Studies US, 2005e).

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[1] Nang meaning prestige
[2] Badal meaning revenge

Muhajir

Muhajir or Mohajir is an ethnic group within Pakistan who speak Urdu and who originally emigrated from India during the partition of 1947. The group is actually composed of people from different ethnic groups and regions in India, such as Uttar Pradesh, Bihar, and Hyderabad. They are united by the Urdu language. Muhajirs are seen throughout Pakistan, with a large population in Karachi. According to Professor M. Mujeeb (2005), the immigrants came from Central Asia, Afghanistan, and Iran. They came because of unsettled conditions in their native land or in search of adventure and opportunity for achievement. Most Muhajirs who immigrated to Pakistan were more educated and thus ended up with better job opportunities.

Baloch

Baloch is a comparatively small group; its roots can be traced to people who migrated from Syria before the Christian era. Baloch speak Balochi, part of the Iranian group of Indo-European languages. Sheep and goats are the main herd animals, and the herder consumes the dairy products himself. The wool of the animals is sold to provide a living for the herders. Leather goods are famous in this region. Balochis' illiteracy rate is very high, as secular education is not promoted because of the Purdah system. Most Balochi girls prefer to marry their cousins; however, marriage choices are dictated by pragmatic consideration. Balochis are famous for their hospitality; this means that providing protection to those who seek it is a Balochi's pride.

Baluchistan's landscape in the 1980s was changed when the Afghan refugees settled in the northern part of the province. Because of the limited population, there has been little development in Baluchistan, except in Quetta, the capital of the province. The Aga Khan Rural Support Development Project, an NGO, has extended its services to rural Baluchistan to address the issue of disparate communities. The major objective of this project is to support groups, and it has had particular success in reaching women in remote areas (Country Studies US, 2005a).

Language in Pakistan

Language is an important indicator of ethnic identity; more than 20 languages are spoken in Pakistan. The most common ones are Urdu, Punjabi, Sindhi, Pakhtu or Pashto, Balochi, Shina, and Brahui. Punjabi, Sindhi, Pashto, and Balochi are also the provincial languages and are spoken depending on the region's population. Forty-eight percent of Pakistanis speak Punjabi; the next most common spoken language is Sindhi at 12%; followed by Siraiki, 10%; Pashto, 8%; Urdu (the national language), 8%; Balochi, 3%; Hinko, 2%; and Brahui, 1%. Additional languages including English, Burushaski, and other languages account for 8% of the population. Instruction in schools was in English until the 1980s. During the government of Zia ul-Haq, "Urdu" was declared the medium of instruction in government schools, but private schools in urban areas were allowed to retain English as a medium of instruction (Exploitz.com, 2004).

Government in Pakistan

The true governance of a country dictates a country's future. It is therefore vital that a country have a clear vision. Pakistan has had difficulty in establishing a stable political situation. The power has shifted between the politicians and the civil military establishment to maintain a stable environment. In 1988 democracy was introduced, which resulted in peace. The constitutional transfer of power to a new government in 1990 and 1993 testifies to Pakistan's progress in the quest for political stability (Country Studies US, 2005c). However, the situation remains volatile; for example, in June 2004 the country faced political instability again when there were strikes and suicides bombs in three places in Karachi.

Religion in Pakistan

Approximately 97% of all Pakistanis are Muslims (Sunni, 77%; Shia, 20%), and Christian, Hindu, and others make up the remaining 3% (World Factbook, 1998). Two major groups in Islam, the Sunnis and the Shia, are differentiated by the Sunnis' acceptance of the temporal authority of the Rashudin Caliphate (Abu Bakr, Omar, Usman, and Ali) after the death of the Prophet, and by the Shia's sole acceptance of Ali, the Prophet's cousin and husband of his daughter, Fatima, and his descendants. Over time the Sunni divided into four major schools of jurisprudence, and the Shia spilt over the matter of succession, which resulted in two major groups. The majority Twelve Imam Shia believe that there are 12 rightful Imams: Ali and his 11 descendants. A second Shia group, the numerically smaller Ismaili community known as Seveners, follows a line of imams that originally challenged the Seventh Imam and supported a younger brother, Ismail. The Ismaili line of leaders has continued to the present day. Prince Sadruddin

Agha Khan was an active member in international humanitarian efforts and is a direct descendant of Ali (Country Studies US, 2005g).

In Pakistan nursing is greatly influenced by the spiritual leader of the Ismaili community, His Highness Prince Karim Aga Khan, who advocated that nursing be viewed as a noble profession and that parents should encourage their daughters to take it up. With this guidance, more Ismaili girls have chosen to become nurses.

It was important to describe the religious and ethnic background because it influences the decisions of young women to select nursing as a profession. From a historical perspective prior to the independence of Pakistan, admissions to schools were reserved for Anglo-Indian and European girls. Thus, the Muslims and Hindus were not enrolled in nursing programs because of prohibition according to their own cultural values. The Brahmins, the higher level in the caste system of Hindus, were forbidden to take nursing because of their religious practices (Hemani, 1996). Muslims girls did not choose nursing as a profession because of its low status and poor image.

Islam and Women

Has the teaching of Islam influenced the nursing profession in Pakistan? Hezekiah (1993), a faculty member at McMaster University, Canada, wrote while teaching nursing in Pakistan that the tenets of Islam are interpreted from a male perspective, which limits women's choices and decisions. Nursing is viewed as an improper and unsuitable profession for good Muslim women even though Islam has given full approval to women to run their own affairs in the way that they want (Boyle, 1989). However, it is hard for most women to act independently in a society where males generally make all of the decisions. Most Pakistani women lead traditional lives, which tends to dictate their personal and professional lives. Hemani (1996) observed, "This gender biased expectation of women, who were dependent on men, has been passed from one generation to the next" (p. 27).

The *Purdah* System

Purdah means veil or curtain in the Persian language. *Purdah* developed in Persia and later spread to Middle Eastern lands. It flourished in ancient times of Babylon (King's University, 2001). During that period women could not go outside unless they were covered and escorted by a male from the family. The believers of Islam see *Purdah* as a respectful practice. Women are looked at as individuals who are judged not by their physical appearance or beauty, but by their inner beauty. For Muslims, *Purdah* is an act of faith that entails the act of honor, respect and dignity. It is practiced in various ways, depending on family tradition, religion, and class. In some families covering the head with *Dupatta* (the cloth that covers the head) is acceptable, whereas others wear *Burka*, a special stitched dress that covers the whole body. The most extreme practice of the *Purdah* system is observed in the North West Frontier and Baluchistan, where most women never leave their homes except when they get married, and they never meet unrelated men.

Purdah, which has influenced greatly the way females are viewed in society, is commonly followed in Pakistan. According to the Holy Quran, women must not display their beauty and ornaments in front of strangers (Hemani, 1996; Vickers, 1992). Thus, this tradition and belief have restricted females from participating in a number of normal activities. In most tribes such as the Sindhi, Punjabi, and Pathan, the head of the family (a man) purchases household goods, including groceries.

Religion has played an important role in creating awareness amongst Pakistanis of the principles of life through the teachings of the Holy Quran. One of the messages of these principles is equality between men and women, but most of the time the worshippers do not understand the interpretation of the Holy Quran. The Holy Prophet, in spreading Islam, emphasized the message of equality. In one of his messages to mankind, the Prophet quoted the following verses of the Holy Quran: "Allah created you from a single soul, and from the same soul created his mate" (4:1). Wives have the same rights as their husbands have according to well-known principles (2:228). Educated people within the Muslim world accept the fact that, although Islam is a complete system (social, economic, and political), it is still affected by the culture of the countries in which it is followed. It is for this reason that some of the rules of Islam appear to be different from one country to another. Many of the differences in Islam that are seen around the world are more cultural than religious. Therefore, in countries where culture includes men's domination of women, the Quran is interpreted in a way that reinforces the cultural trait of male-gender domination.

Role of Education in Women's Empowerment in Pakistan

Women have never been treated equally in Pakistan's male-dominated society. They have been prevented from using their intellectual capabilities in spite of being highly qualified. The professional qualifications that women achieve must be sacrificed for the ethos of the society, which is that after marriage a woman's responsibility is to give birth, take care of the family, and look after the house. All of these responsibilities made it was impossible for women to continue a career. Even today in some tribes in Pakistan—for example, Sindhi, Pathan, and Balochi—women are excluded from employment opportunities that require contact with men. This belief has greatly influenced nursing and nurses and has added to the low status of nurses in the society (Amarsi, 1998; Gul, 1998; Wazir, 1993). This attitude has been instrumental in leading to the shortage of nurses in the country for the last five decades (Government of Pakistan [GOP], 1995; Wazir, 1993).

There are 24,776 registered nurses (RNs) and 78,140 registered physicians (GOP, 1988) for a population of approximately 150 million, one nurse for every 5,328 persons, and one physician for every 1,689 persons (World Bank, 2000). Although measures have been taken to improve the status and enrolment of nurses in nursing schools in the country, these strategies have failed to a large extent for economic, political, and social reasons. An extract from a GOP (1988) report on the Status of Women stated that Pakistani women are socially, educationally, and politically far behind their male counterparts.

The rate of female literacy is appallingly low, particularly in rural areas. As daughters, sisters, wives, and often even as mothers, they have no real voice in the family's decisions, and their usefulness depends largely upon how efficiently they serve the family in the humblest possible manner. One of the major reasons for the low status and image of nursing is that female education is not highly valued. In 1990-1991 only 35% of Pakistani girls were enrolled in primary schools compared to 63% of boys (Hemani, 1996). Thus, illiteracy, particularly female illiteracy, is still a serious social problem in Pakistan. Over half of the adults in the Middle East, South Asia, and Africa are illiterate. Official statistics show that only 14% of women have had schooling, and in 15 of Pakistan's 75 districts, less than 1% of women can read and write (Zindani, 1996).

Pakistan has never made systematic efforts to improve female education. According to the information, the reason for low female school enrolment is cultural bondage. The research conducted by the Ministry for Women's Development and a number of international donor agencies in the 1980s revealed that the danger to a woman's honor was her parents most crucial concern (Country Studies US, 2004b).

Nursing

The term *nursing* needs to be understood to create a framework that clarifies the role and responsibilities of the nurse in the health care setting and to highlight some of the important aspects of nursing in Pakistan. Nursing a patient is a practical art with its own dialectic—the analysis that arises out of critical thinking. The role of a nurse is therefore important worldwide in meeting patients' needs. The goal of nursing is to discover human experiences of health and illness, which, as Koldjeski (1990) argued, places nursing in a different reality from traditional health care, medicine, and technology. Nursing practice, as Biley (1992) defined it, involves using intuition and practical experiences to develop the art of nursing. It involves formulating the foundation of a knowledge base that links with research and scientific inquiry and adapts new knowledge for better patient care based on sound judgment. The role of a nurse becomes critical at the macro level to promote the concept of health for all. The goal of providing care to patients and clients can be seen as occurring only if nurses have knowledge of disease processes and health prevention and the skills to care for individuals. In 1983 Rogers suggested that nursing is not a summation of facts and principles borrowed from the other disciplines, but an emerging new science, the science of Unitary Human Beings

(Malinski & Barrett, 1994). This means that nursing is unique, although some concepts are taken from other sciences. I believe that nursing's uniqueness is its focus on caring.

Medical technology and new innovations have done a great deal to meet the physical needs of the patient but have failed to meet the criteria of holistic care, which includes caring. Leininger (1986) stated that "nursing is caring; caring is the heart of nursing; and care can be powerful means of healing and promoting healthy life ways" (p. 3). In today's society, however, nursing demands a holistic approach to patient/client care that addresses physical, social, spiritual, and psychological needs. The literature placed caring at the core of nursing, and Lanara (1993) concurred, suggesting that caring constitutes a unifying force in nursing. One aspect of caring is the necessity to be sensitive to people's cultural needs.

Education for the future within the nursing curriculum should therefore incorporate modules that consider transcultural issues, perceptions of health care, advanced nursing practice, and nursing theories. Nurse educators consequently need to be aware of the implications of transcultural education in nursing to provide culturally sensitive nursing care to patients and clients. According to Quinn (1995), the term *culture* refers to the civilization and customs of a particular people or group, their whole way of life. Leininger (1986) defined *transcultural nursing* as "the subfield of nursing that focuses upon a comparative study and analysis of different cultures and subcultures in the world with respect to their caring behavior; nursing care; and health illness values and beliefs, and patterns of behavior" (p. 56). Therefore, the goal of transcultural nursing is to develop a scientific and humanistic body of knowledge to provide culturally specific and culturally universal nursing practice (Tschudin, 1992). Because nursing has always been concerned with human caring, it is also crucial that nurses be aware of cultural values if they are practicing in a multicultural society. This is especially true for a country such as Pakistan, which is multicultural in that it contains many different groups; for example, Hindu, Sindhi, Pathani, Afghani, and Bahari. The issue of culture is also important in relation to the differences between women's and men's cultures in general and the particular differences among women's cultures around the world.

Nightingale's Influence on Nursing

Nightingale nursing is addressed to give the reader an overview of nursing during the time of Florence Nightingale, because her ideas have had an impact on present-day nursing in Pakistan. Nightingale's system of nurse training was founded on three fundamental principles. The first was that the role of the matron, who had complete control over nursing, was to ensure that physicians did not manage the nurses. In Pakistan in the government sector, the matron was replaced by a new management position called the *nurse in charge* after the partition of the Indo-Pakistan Subcontinent in 1949. However, the nurses in charge have lost their power since 1949 and handed it over to medical officers for the management of hospital routines. It is common practice that most of the ward routines and schedules, including the hiring of nurses, have to be approved by a medical officer. The second principle of Nightingale's training approach was that nurses should be trained for their work by acquiring both skills and knowledge. Despite Florence Nightingale's own intention to maintain a balance between theory and practice, training was largely focused on the practical aspects of the profession. Nurses in Pakistan are still being trained in this way. In fact, in most hospitals nursing students manage the ward routines. The third principle of the Nightingale system was that the character of a nurse is just as important as her technical efficiency in terms of patient care (White, 1988). For many years nurses in Pakistan have been considered to be of "low" character. They have been seen as sex objects who have come from low socioeconomic groups, with marginal education, entering the profession not by choice but because they have no alternative plan for making a living. However, this impression is changing in society with the advancement of nursing knowledge.

The Nursing Profession in Pakistan

Nursing in Pakistan has not been recognized as a professional occupation as it has in other Muslim societies; for example, in Saudi Arabia it has a higher professional status (Boyle, 1989). In Pakistan young women are rarely supported in taking up nursing as a profession because it is perceived as a menial occupation. Nurses are considered docile and submissive (Miller, 1996) and subject to the authority of male physicians. In a study that Harnar, Amarsi, Herberg, and Miller (1991) conducted on physicians' attitudes towards nursing at the AKUMC, they concluded that physicians view nursing neither as a respectable career option nor as viable. The above findings reflect the sociocultural norms and values in Pakistani society that are the major sources of the challenges that the nursing profession faces in that society.

Zindani (1996), a nurse leader who analyzed the above situation, suggested that the motivation for policy changes in nursing education and curriculum has to come from nurse leaders, who first need to increase the public's awareness of nursing so that it becomes accepted as a profession. Achieving respect and status for nurses in Pakistan means having to compete with the above-mentioned cultural norms and values, which must change. People have assimilated these cultural conventions from their childhood, and there is little intellectual connection to their content; they are merely part of the way of life. As such, they will be the most difficult barrier to remove (French, 1994; Miller, 1996; Zindani, 1996). Miller advised:

> Nurses need to educate and prepare for administration, education, practice and research in nursing, be able and willing to lead the profession, to set standards and practice and to work to influence health policy formulation at the Federal and Provincial government levels. (p. 67)

Miller's prescription is to bring about change through the medium of education. Even though she conducted her study within the culture and she acknowledged the role that cultural conventions play, she put the emphasis on education as the way to move forward.

Another major challenge to the establishment of nursing as a profession for women in Pakistan is the paucity of nursing leaders and role models at all levels (Miller, 1996; Zaki, 1976). Zaib (1993) noted that nurses are in short supply in Pakistan. In this respect, a number of attempts have been made over the years to overcome this deficiency, mainly by increasing the number of schools of nursing. Even though there are more schools and the criteria for entry to the profession were lowered, the number of recruits to the profession has still not significantly increased. One of the reasons may be drawn from French's (1991) study, which indicated that nurses' low living, training, and working conditions have contributed to the lack of respect for nurses and their occupation's low social status. This has resulted in insufficient numbers of nurses to meet the health needs of Pakistanis.

The current graduate nurse salary in Pakistan is around CAD $125-$150 per month and of a nurse teacher is around CAD $200-$250 per month. This situation is a reflection of the society's values and how they have impacted the profession of nursing.

Miller (1996) identified this shortfall in Pakistan: "Nursing leaders, well educated, highly qualified nurses are in short supply" (p. 22). Fifty-seven years have past since Pakistan's independence, and I question whether progress has been made in the nursing profession. I believe that the progress of any profession depends on number of conditions, one of which is the support of its government. Pakistan has been politically unstable since independence because of the frequent changes in the government system; this may have contributed to the challenges that nurses face in trying to advance the profession.

Healthcare Politics in Pakistan

Improvements in health care have been hampered by scarce resources and are difficult to coordinate nationally because health care remains a provincial responsibility. Until the early 1970s local governing bodies were in charge of health services (Wolfer, 1987). National health planning began with the Second Five-Year Plan (1960-1965) and continued through the Eighth Five-Year Plan (1993-1998). Provision of health care for the rural population has been a stated priority, but efforts to provide such care continue to be challenging because of difficulties in finding staff for rural clinics.

In the early 1990s the orientation of the country's medical system, including medical education, continued to favor the elite. There has been a marked increase in private clinics and hospitals since the late 1980s. However, it is unfortunate that deterioration is evident in the services that government hospitals provide, where the majority of the population seek medical care (Country Studies US, 2005d).

In addition to the public and private sector providing health care, local forms of treatment are also practiced in Pakistan. Herbal treatments are used to balance bodily humors. *Hakims* (healers) are approached to treat clients who are thought to be captured by black magic. Religious approaches that follow the guidance of the Holy Prophet's teaching, called *hadith*, use, for example, honey, herbs, and prayer. *Tawiz* (amulets containing Qurani verses) are considered spiritual approaches to healing and are used to treat diseases.

Cultural Influences on Nursing

Nursing in Pakistan has been influenced by a number of factors that are sociopolitical as well as cultural. As indicated earlier, there were 24,776 RNs and 78,140 registered physicians in 1988 (GOP, 1988). Hence, there was one nurse for every 5,328 persons and one physician for every 1,689 persons (World Bank, 2000). Zindani (1996) indicated a critical shortage of RNs, whose number was estimated to be between 8,000 and 16,928, or a mean ratio of one RN to 10,000 inhabitants. This discrepancy in nursing registration in Pakistan is probably related to the input of data, which was done manually and was therefore prone to human error.

The other issue with the registration process is related to overestimation or counting. For example, an RN, a registered midwife (RM), and a nurse with a bachelor's degree are sometimes counted three times instead of only once even if only one person has these qualifications. The reason for this is that the entries for registration are made by qualification rather than by individual. It was not until 1998 that the Canadian International Development Agency (CIDA) began to help the registration office in Islamabad to update registrations. The planning included entering the data into a computer to create a current and accurate registration system. However, the registration process could not be completed within a given time frame because the employees had to be trained on the basic skills of computer operation before the actual process could be started. As stated above, 1999-2000 estimates indicate one nurse for every 5,328 persons. One may wonder whether the World Bank (2000) figures reflect reality or whether they are affected by overestimates such as those just described.

Multiple factors have inhibited the growth of nursing in Pakistan, and some are problems associated with the retention of nurses in the workplace. Their menial status often means that the population takes them for granted and gives little thought to their place in society. This is not a situation guaranteed to encourage women to either enter or remain within the profession.

The Image of Nursing in Pakistan

The poor image of the nursing profession and the lack of a strong nursing voice have seriously inhibited the ability of nurses to influence changes at the policy level. Considering the realities of the nursing profession and the role of women in Pakistan, CIDA took the initiative and created an awareness project directed at women in Pakistan towards raising the status of nursing, the Development of Women's Health Project, in collaboration with the government of Pakistan.

In CIDA's (1993) project report, one of the objectives listed was to improve the capacity of the country's nursing profession in leadership positions. It was suggested that nurses should participate effectively in health policy and planning activities (Zaib, 1993). It is all very well to claim that nurses need to be involved in positions of authority to have a political voice, but before this can take place, nurses must take the future of their profession into their own hands and become effective in this respect as a precursor to becoming effective leaders.

Governing Bodies of Nursing in Pakistan

The context of nursing in Pakistan would be incomplete without illustrating the roles of the governing bodies. The governance of nursing in Pakistan at the provincial level occurs through the Nursing Examination Boards, which are guided and supervised by the Pakistan Nursing Council (PNC). Each of Pakistan's four provinces—Sindh, Punjab, Baluchistan, and the Northwest Frontier Province (NWFP)— has its own Nursing Examination Board, Provincial Secretary of Health, and Controller to regulate nursing examinations province. The responsibility of the Controller is to ensure that the nursing exams are conducted as per institution policy, which includes identifying the examiners who set the examination papers based on their specialty in the subject. The nursing papers are set by nursing personnel and by a medical officer (physician). Physicians examine nurses because in some nursing schools physicians still teach subjects such as physiology, surgery, and pharmacology. The Board exams are held twice yearly in March and September. Providing guidance for the examination is the responsibility of the PNC, which is the regulatory body, but the administration of the examination is the responsibility of each province. There are four examination boards, and exams are held at the same time in all provinces to maintain consistency in the process.

Nursing students have provincial exams yearly that include practical and written components. All nursing students from private, public, and military institutions must succeed in the provincial exams to obtain a diploma for practice. For example, in Year I there are three practical exams: anatomy and physiology (A&P), fundamentals of nursing (FON), and community. A&P practical exams include 'viva' (an examination process in which questions are asked) from nine systems; students are required to identify the bones (human skeletal), which tends to be challenging for nursing students because most of them have not seen real bones during their course program. The next practical exam requires that nursing students demonstrate basic skills such as bed making and setting up trays, as well as checking vital signs, administering hot and cold compression, and testing urine, which are components of the FON. For the community practical examination, students visit a community; conduct a community assessment, complete the assessment form, and are asked questions based on the observation and assessment done.

In Year I nursing students are tested on six papers—three nursing and three non-nursing. The nursing courses are FON, A&P, and community; and the non-nursing courses are Islamiat (based on Islam), English, and sciences. Until 1997 (R. Gul, personal communication, November 12, 2004) the entire examination process was subjective. However, changes have been implemented in nursing papers by including multiple-choice questions (MCQs), with a ratio of 40 marks for the MCQs to 60 marks for the essay. If a nursing student fails the nursing exams, she is not promoted to the next year of the program until she passes the course subject. In such cases the students write the March exams, which are six months later than the schedule date. During this period a nursing student is expected to work in the clinical area and prepare for the exams. In the same way, Years II and III nursing students are tested on the components indicated in the PNC curriculum document. Although the PNC intended to have national exams, with CIDA's support, this mission could not be achieved for undetermined reasons.

Pakistan Nursing Council

After the partition of the Indo Pak Subcontinent, the Pakistan Nursing Council Act was passed in 1973. At this time the Provincial Nursing Council was dissolved and replaced by the PNC. Under the new act, four examination boards were established in each province to cope with the workloads. With this process the responsibility for conducting the examinations and awarding the diplomas became each province's responsibility. The PNC still had three major tasks under its umbrella: developing the criteria for the admission process, setting curriculum, and approving the institutions and registration of the nurses. The major responsibility of the PNC has been to ensure that the current requirements of the country's health needs are incorporated into the curriculum. Each nursing institution in a province has to register with the PNC, which formulates the rules and regulations (code of practice) that nurses need to follow in practicing the profession in the country. Pakistan nursing has its own code of ethics that was developed in 1949 and revised in 2002 with WHO sponsorship (R. Gul, personal communication, November 9, 2004). It is the PNC's responsibility to accurately maintain and update the nursing registration process in the country, which includes data from all four provinces in Pakistan. Nursing registration is mandatory according to the PNC's documents; however, it has been observed that most of the nurses do not maintain current registration. Nurses in Pakistan do not receive a reminder of the expiry date, and, furthermore, no evidence of registration is needed to practice. For example, a nurse who has not worked for 10 years can renew registration by paying the dues for those years and receive a current registration valid for five years.

The Pakistan Nurses Federation

In 1971 Pakistan was divided into two parts, East and West Pakistan, after the so-called War of Independence. As stated earlier, Pakistan was further divided into four provinces, which resulted in the change in governing bodies. The need for the Pakistan Nurses Federation (PNF) arose in July 1972. The PNF includes three levels of management: the headquarters and the provincial and branch levels. The headquarters is composed of a national executive board, including representation from the four provincial associations and the governing body, and an executive board. At the branch level the executive committees are divided into operational groups (Hemani, 1996). The provincial associations' membership is constituted of nurses, midwives, and lady health visitors. Each provincial association responsible for working for the benefit of its members through negotiations with the government. Zindani (1996) explained that the objective of the PNF is to become a truly professional association that can respond to its members' needs, initiate changes to protect and improve the role of nurses, keep members abreast of technological advances, and lobby for changes to nursing in Pakistan.

The struggle for professional stability continues, and in 1992 the PNF was able to pay the International Council for Nurses (ICN) fees. In 1993 the Canadian High Commission funded two members from Pakistan to attend the ICN meeting in Spain (Hemani, 1996), and in 1997 five nurses were sponsored to attend the ICN Vancouver conference. The progress may seem slow, but there is hope that nursing in Pakistan will achieve its goal of being recognized internationally.

The Nursing Educational System in Pakistan

A modern historical review of the nursing education system in Pakistan, as Hemani (1996) described it in her master's thesis, begins in 1960, when the nursing curriculum was revised for the first time after the partition of Indo-Pakistan in 1947. Subjects such as psychology, sociology, and ethics were added to nursing programs. However, changes in the curriculum could not be implemented because of the scarcity of trained nursing instructors, the lack of classrooms, and the use of students in ward settings.

Nursing education in Pakistan is characterized by three-year diploma programs offered by a total of 77 schools of nursing, 53 of which are public programs (government sponsored), one of which is semipublic, five of which are military, and 18 of which are private. Nursing students have to pass provincial nursing board examinations at the completion of the program to obtain a nursing license and be eligible for registration.

The first degree program at a post-basic level was introduced at the AKU in 1988. At the end of two years of study, diploma-prepared nursing students receive a Bachelor of Science in Nursing (BScN). Nurses who do not wish to complete a BScN have an alternative. After completing a three-year diploma, a nurse can write two examinations in English and Islamiat offered by each provincial educational board and be granted a general bachelor's degree. There is also a four-year BScN program leading to entry to practice, which started at the AKUSON in 1997 with 37 students from all over Pakistan. It is the only program of its kind in Pakistan. It aims to provide the foundational knowledge, skills, and attitudes needed to practice nursing and is dedicated to preparing clinically competent professional nurses. In addition, the first Master of Science in

Nursing (MScN) degree program in Pakistan with a focus on advanced nursing practice began October 2001 at AKUSON.

Role of the Aga Khan Foundation

The worldwide Aga Khan Foundation has played a major role in establishing the Aga Khan University Hospital (AKUH) and the school of nursing in Karachi. This foundation has taken major steps in Pakistan to raise the standards of nursing in the country and to improve the health delivery system by introducing modern nursing education. This task was accomplished by establishing the AKUSON in 1980, which is a well-recognized educational institution and an integral part of the AKU in Karachi. Its major goal is to educate nurses who can provide nursing care that meets the health needs of urban and rural populations. The school also aims to provide leadership in nursing education, practice, administration, and research and thereby enhance the status of the nursing profession in the country (Miller, 1996; Vellani, 1994).

The Aga Khan Foundation, with the help of the AKU, McMaster University, and CIDA, has been working to strengthen the role of nurses and nursing in the country. On November 22, 1996, the Chancellor of the AKUMC (Prince Karim Aga Khan) launched four major funded projects aimed at strengthening and expanding nursing education, specialized diagnostic services, advanced research, and community health care. Dr. Paula Herberg, the Director and Associate Dean of the AKU, in her inaugural address at the new building of the School of Nursing, officially declared a building, Rufayda Al-Aslamiya, named after the first Muslim nurse. According to Dr. Herberg, the project was a major expansion of the physical and programmatic capacities of the school, on both the national and the regional level.

To date AKUSON has educated 1,705 nurses who are working in different capacities in the health care system (Y. Amarsi, personal communication, July, 8, 2002). The curriculum focuses on quality education and integrates community-oriented values into nurses' education, which has been pivotal in changing the public's image of nursing. Pakistan became a country represented in Sigma Theta Tau International (STTI) in 2000, and AKUSON became a member of this society devoted to the development of nursing knowledge. This has been a major step in enhancing nursing in the country.

AKUSON offers several nursing programs. Track 1 is a prepreparation nursing program for students who come from deprived areas; its aim is to strengthen their knowledge of the basic sciences and the English language. As stated earlier, a three-year diploma, four-year BScN, two-year post-BScN, and MScN are also offered. The four-year BScN and the MScN are the only programs of their kind in Pakistan. The goal is to achieve the objectives set for these programs. For example, at the completion of the four-year program, graduates are expected to demonstrate responsibility and accountability to the nursing profession by adhering to the established patterns of professional practices. They are expected to utilize effective critical thinking and problem solving in caring for the individual and the community. As well, they must develop leadership skills to promote development of the profession.

The goal of the master's program is to prepare graduates who will be able to demonstrate competence, influence policies while managing care, and contribute to nursing knowledge throughout the region by conducting research and engaging in professional activities to benefit the profession. These objectives were determined based on the needs of a country where nurses have an active role to play at the management level. Nurses at the master's level are prepared to take on challenges by conducting research and disseminating the findings in the fields of education, management, and practice.

The overall objective of the post-RN BScN is to prepare nurses to utilize effective critical problem-solving skills to bring about changes in nursing education and management practice. The terminal objectives for these programs vary based on the level objectives. AKUSON is not confined to Pakistan; its innovative programs has extended internationally to East Africa with the Advanced Nursing Studies Program (ANS; AKU, n.d.b).

Curriculum

One may question why I have included nursing curriculum in this context, but I believe that because curriculum acts as a foundation in the educational system and provides more structure and meaning to a program (Allan & Murrell, 1987), it is therefore crucial to understand its basic functions in relation to nursing education. Curriculum dictates the direction for the future. It reflects the needs of the students and of society. The major responsibility of the nursing educator is thus to develop a strong educational foundation for students to cope with the challenges of the world. In the current study I do not intend to explore the relationship between nursing education and the curriculum. However, the importance of curriculum implementation in the nursing education system cannot be ignored (Bevis, 1982; Bevis & Clayton, 1988).

The nursing curricula in Pakistan are approved by the PNC to ensure that the standards are maintained while implementing the nursing curriculum in all provinces However, because of the shortage of qualified nurses and increased demand for nurses in the country, it is not possible to implement the curriculum in its true sense. For example, there are at times two clinical teachers for a group of 80 students, which is truly outside of expected norms. Therefore, the implementation of the curriculum in Pakistan varies from one institution to another depending on the type of health care facility.

Health Care Facilities in Karachi, Pakistan

It is important to discuss the existing health care facilities of Pakistan because they have an influence on the delivery of nursing education. Pakistan has three types of hospital facilities that provide health care service: public hospitals, semiprivate hospitals, and private hospitals, most of which are linked with a school of nursing.

In public or government hospitals, there are no charges for health care; as a result these hospitals provide services to less-fortunate patients who come from rural areas. The ratio of nurses to patients is usually 1:50. Resources are often not sufficient. For example, there might be one cardiac monitor for 40-50 patients. Most of the equipment is outdated and nonfunctioning, which makes patient diagnosis and treatment difficult. In these settings, typically, second-year nursing students work independently on evening and night shifts.

In semiprivate hospitals certain aspects of care are funded by the government, whereas other services are paid for by the individual client or patient. The quality of care in semiprivate hospitals is comparatively better than that in public hospitals. Nursing students are scheduled to work along with a staff nurse or clinical teacher.

In private hospitals the care system is outstanding, with sufficient materials and human resources to meet the health-care demands of the patients. Because health care here is expensive compared to that in the other facilities, most patients come from affluent classes. Nursing students are accompanied by a clinical teacher and are not scheduled for night shifts. The ratio of student to teacher is usually 8-12 per faculty. Thus, the major responsibility for patient care in private hospitals rests with staff nurses.

Significance of the Proposed Study

Clinical learning is the heart of a nursing student's professional education (Morgan, 1991). Clinical practice provides the opportunity for students to become skilful through implementing theoretical knowledge in a practical situation. Benner (1984) stated that "theory offers what can be made explicit and formalized, but clinical practice is always more complex and presents many more realities than can be captured by the theory alone" (p. 36). Thus, clinical practice provides a rich experience in learning how to apply theoretical concepts to practice. The student is challenged to examine and try new modalities of care, which requires critical thinking, psychomotor skills, and a professional value system (Bulmer, 1997). Therefore, the goal of nursing is to educate nursing students to apply theoretical knowledge to practice. Clinical teaching is complex in nature and requires integration of knowledge and skills into the practice setting (Diekelmann, 1990; Karuhije, 1997; Scanlan, 1996). With the changes in the health care system, the nursing education system is faced with more challenges to prepare competent nurses. Clinical teachers play an important role in assisting students to acquire the knowledge, affective attitudes, and psychomotor skills necessary for the professional practice of nursing (Clay, 1992; Fetwell, 1980; Hermann, 1997).

Clinical teaching not only helps students to enhance and strengthen basic skills in routine tasks such as providing hygienic care, dispensing medications, changing dressings, inserting nasogastric tubes, changing colostomy bags, and inserting catheters, but also guides students in developing critical-thinking skills and leadership qualities. There is no doubt that educators today need a variety of role competencies to prepare the next generation of clinicians (Choudhry, 1992; Krisman-Scott, Kershbaumer, & Thompson, 1998). Limited research has been conducted on how clinical teachers learn to teach and what thinking and knowledge dictate their teaching practices. The deficiency in research evidence may be one of the factors leading to feelings of frustration in performing their work. The foci of most of the research carried out in nursing on clinical teaching have been on teaching behaviors (Bergman & Gaitskill, 1990). A study conducted in the United Kingdom indicated that clinical teaching has undergone changes over a period of time to meet the requirements of the national framework (Andrews & Wallis, 1999). This evolution has affected the role of nursing students and clinical teachers in nursing education (Arspin, 1982; Nearly, Phillips, & Davies, 1994; Yegdich, 1999).

In nursing education there is an assumption that if a nurse is good in the practical area, he/she is a good teacher. In response, Fitzpatrick, (2001) argued that in most circumstances a knowledgeable person may in fact be incapable of transmitting knowledge to students effectively. This study revealed that a good practical nurse will not necessarily be a good educator. Karuhije (1997) noted that clinical teaching requires a different set of skills. However, during the literature search I was able to find limited information on the process of clinical teaching. The lack of exploration of this topic is surprising given the fact that clinical experience is considered an integral part and a necessary component of nursing education (Pugh, 1980).

The importance of clinical teaching cannot be ignored; it contributes to the socialization of nursing students into professional roles. The process is intended to create social awareness, ethical and moral accountability, and responsibility to society. Clinical experience is essential for nursing students to foster a sense of responsibility for their own actions. It also enhances competence and the critical-thinking skills that nurses need. Working as a clinical teacher in Pakistan, I always questioned what makes the clinical experience a memorable and lifelong learning experience for nursing students.

Clinical teaching is an essential component of nursing education, and yet limited research and personal reflections from developing countries are available. Novice clinical teachers need to be aware of the basic issues in clinical teaching, such as the teaching and learning strategies implemented in the past to enhance students' learning. In addition, new teachers need to be familiar with different assessment tools that are used consistently and objectively to assess nursing students in the clinical area.

In examining nursing in Pakistan, I will now explore the concept of clinical teaching in the country. Different studies have been conducted in Pakistan to explore the problems in human resources, the shortage of nurses in the country, leadership in the profession, and the image and status of nursing and nurses in Pakistan. This research is the first of its nature to study clinical teaching in Pakistan. It is my strong belief that if nursing in Pakistan is to have a position in the international world, nurses must be competent professionals. Assuming that clinical teaching has an impact on this learning, it is important to explore how this teaching is carried out in Pakistan.

Problem Statement

Nursing is a practice-based profession, and a significant part of any nurse's education is spent in practice areas, gaining first-hand experience. Facilitating effective learning in the clinical area depends on a number of factors. In my view the role of the clinical teacher is critical. It is recognized that the presence of the students in the clinical area will not ensure the acquisition of the desired competencies (Farrington, 1993; Reilly & Oermann, 1999). In Pakistan nurse teachers have dual roles as classroom and clinical teachers. However, I believe that there are few clinical teachers in the country who are able to contribute positively towards students' learning in the clinical setting.

Adequate nurse-education preparation has been an issue for most developing countries. Preparing a nursing faculty member involves developing the ability to fulfill a clinical as well as a classroom teacher role. It is of utmost importance that the clinical teacher be able to help students to apply knowledge gained in the classroom in the clinical setting (Davis, Dearman, Schwab, & Kitchens, 1992). Griffin (1995) suggested that "a clinical teacher education program should be context sensitive, purposeful, participatory, collaborative, ongoing, developmental, analytic and reflective" (p. 76).

In addition, Krisman-Scott et al. (1998) advised that the content for faculty preparation programs include adult learning principles, factors that affect student readiness to learn, critical thinking, curriculum processes, curriculum development, evaluation, test construction, and teaching methods and strategies. Upvall et al. (2002) and the faculty of the AKU found that there were no requirements from the Nursing Council or other institutions in Pakistan that faculty maintain clinical competence or even be present with students in the clinical area. The above research pointed out one of the major weaknesses in the nursing education system and indicated a need for research to explore the role of the clinical teacher in Pakistan. This is a complex situation but nevertheless a reality of nursing education in Pakistan.

Definition of Terms

For the purpose of this study, the following terms are defined:

Teaching

Teaching is a facilitative activity or process shared between two or more individuals that involves interaction between teachers and students. The objective of teaching is to achieve cognitive and behavioral changes in students.

Learning

"Learning is the process whereby knowledge is created through the transformation of experience" (Kolb, 1984, p. 43).

Clinical Teaching

Clinical teaching is the process of facilitating the learning needs of students in the clinical area to achieve set objectives. Clinical teaching requires skills and knowledge of practice and research.

Clinical Teacher (Nursing)

A clinical teacher is an individual who is actively involved in clinical teaching, a nurse (mentor, tutor, clinical teacher, clinical faculty, ward sister, nursing staff, staff nurse, link teacher, or preceptor) assigned to work with the students in the clinical area to accomplish the clinical learning objectives. A clinical teacher may be from service or education and is assigned to nursing students based on competencies. A clinical teacher is skilful and knowledgeable in conveying nursing information to nursing students using various teaching and learning strategies.

Learning Environment

The ideal learning environment is defined as a unit where teamwork is evident and communication is effective (Orton, 1981). In this environment a clinical teacher is aware of the physical and emotional needs of students. The environment is nonthreatening and promotes opportunity for learning and practicing nursing skills.

Clinical Setting

The clinical setting is a unit or ward of a hospital, agency, or community where a nursing student gains practical experience.

Objectives of the Study

The purpose of the study was to explore the process of clinical teaching in Pakistan from the perspectives of clinical teachers and nursing students by seeking the answers to six research questions:

1. What is the nature of clinical teaching in Pakistan?

The answers to this question provided descriptions and understanding of clinical teaching in Pakistan in both private and government institutions. Specifying Pakistan in the context is important; because it is a developing country, the emphasis of the nursing curriculum is to delivery health care to patients by focusing on the resources available.

2. What are the characteristics of effective clinical teachers in Pakistan?

The answers to this question provided data about the attributes of effective clinical teachers in promoting learning in clinical areas and whether it is knowledge, experience, skills, or humanistic qualities that teachers and students consider important.

3. What facilitates clinical teaching in Pakistan?

The answers to this question led to a discussion of the factors that promote learning in the clinical area, such as the clinical teachers' past experiences, expertise in the subject area (knowledge and skills), rapport with the staff and the management of the hospital, orientation to the ward and routines, coping strategies, and a philosophy of learning. The question also led to reflection on students' philosophy of learning, anxieties, learning competencies, present and past clinical exposure, and mental and physical stability. In addition, the responses brought to the forefront management issues such as the number of students in a group, clinical placement and the opportunity to practice skills, the type of facility, the availability of equipment, guidance and support from the clinical teacher, clear evaluation strategies, and liaison between service and hospital and policies.

4. What are the practical challenges in clinical teaching in Pakistan?

The answers to this question provided data about the challenges in regard to resources: material, human, and financial. Issues such as clinical placement, availability of learning material (computers, recent nursing references), organizational policies, number of students, the clinical teacher's expertise in the practice area, and clinical hours were addressed.

5. What are the cultural barriers to clinical teaching in Pakistan?

The answers to this question examined cultural and traditional values that act as barriers and led to an analysis of how these barriers could be incorporated or overcome in an Islamic country. Issues related to the *Purdah* system were also discussed.

6. What are students' views on clinical teaching in Pakistan?

This particular question was purposely kept broad to obtain in-depth understanding on the topic from the nursing students' perspective.

Conclusion

In this chapter the following topics have been discussed: (a) background information on Pakistan that focused on ethnic and religious organization, (b) the historical period of nursing during Florence Nightingale's time and its relationship to the current situation of nursing in Pakistan, (c) the nursing education system and its influence on the health care system, (d) the various factors that influence nursing in Pakistan such as the sociopolitical and cultural factors that have indirectly affected the recruitment and retention of young women in the profession and have led to nursing's poor status and image in the country, (e) the roles of the governing bodies (the PNC and PNF), (f) the responsibilities of the AKUH and CIDA in relationship to empowering nurses in Pakistan, (g) the significance of the proposed study, (h) the problem statement, and (i) the objectives.

CHAPTER TWO:

LITERATURE REVIEW

The purpose of this chapter is to present the literature review on the topic of clinical nursing education. The first section of this chapter includes a discussion on how I conducted the literature search. It is followed by a review of the literature on clinical education and clinical teaching, definitions of clinical teaching and clinical supervision, a historical perspective on clinical practice in nursing education, models of clinical teaching, clinical teachers, the components of clinical teaching, stress associated with clinical experience, and clinical placements.

Literature Search

The journey for this literature review began with a search on the broad topic of *clinical teaching*. I conducted database searches in CINAHL, ERIC, and MEDLINE. The literature search became challenging and demanding because of the extensive amount of material under the search terms *clinical* and *teaching*. This search led me to the literature related to nursing practice and issues such as staff development, continuing education, staffing, the development of practical skills, shortages, workload, and job expectations. Academic issues of the nursing student and clinical teacher in regard to clinical experience were comparatively limited. I further refined the search by using the following key words: *teaching and learning*, *supervision*, *practical*, *skills*, *work-associated stressors*, *assessment*, *competence*, *feedback*, *evaluation*, *grading system*, *placement*, *learning environment*, *mentorship*, *preceptorship*, *clinical teacher*, *mentor*, and *preceptor*.

Limited published information was available on clinical teaching in Pakistan; as a result, I explored different strategies to generate information on the situation in the country. I also contacted Pakistani nursing leaders by telephone and through e-mail to collect information pertinent to the study.

At the beginning of the search I found about 12,000 articles on the topic of interest. Refining the search reduced the number of articles to 600 that were more directly relevant to the topic. I further classified these articles into two main categories, research and non research articles, and sorted them according to the content, which I then classified into four general categories. The first category dealt with the clinical teaching aspects, such as the definition of *clinical teaching* and *supervision*; a historical overview; models of clinical teaching; and related issues. The second category focused on assessment, challenges, common terms used such as *competence* and *mastery*, and assessment tools. The third category included the stressors of the clinical area on clinical teachers and nursing students and considered student-teacher ratio, resources, and placement. The last category focused on evaluations, process, tools, and issues attached to the grading system.

Dividing the articles into these categories was difficult because one category factor had an influence on the outcome of another component. For example, to evaluate a nursing student's performance in a clinical area, a clinical teacher focuses on the clinical objectives and competence level, the type of clinical placement (acute or chronic), knowledge and skills in clinical assessment, assessment tools, the ratio of students to teacher, the availability of resources, the opportunity provided before evaluation, and the institutional policy on assessment.

Clinical Education

Clinical education is recognized as an essential and highly significant component of the professional education for nursing (Bevil & Gross, 1981; Wellard, Rolls, & Ferguson, 1995; Wilson, Soldwisch, Jacobson, & Robertson, 1995). It is during the clinical experience that the process of socialization into the professional role begins (Dunn, Stockhausen, Thornton, & Barnard, 1995), and in the clinical area students relate theory to practice, learn the necessary technical and interpersonal skills, and make clinical judgments (Dunn et al., 1995). Clinical education is also considered a core element of nursing curricula (Ferguson, 1996; Lee, 1996; Pugh, 1980; Reilly & Oermann, 1992), and its weight as a crucial component of professional nursing education has been recognized. Therefore, some researchers have described how neophytes achieve professional values, norms, and attitudes required in nursing (e.g., Benor & Leviyof, 1997).

A clinical teacher plays a vital role in nurturing nursing students for the above-mention professional roles. Clinical education, under the guidance of the nurse educator, has been depicted as a medium in which teacher, student, and patient exist in a triad for the principal purpose of allowing the student to learn to become a clinician (Paterson, 1997). Clinical practice allows students to learn and develop problem-solving skills, progress in their commitment, and collaborate with other disciplines in resolving client problems (Paterson, 1997; Pugh, 1988; White & Ewan, 1991).

Reilly and Oermann (1992) portrayed clinical education as a union of the clinical environment and experiential learning in which students step into the experience to acquire knowledge and skills. The acquisition of this knowledge may be unsuccessful if the clinical teacher is not competent in performing his/her role. Diekelmann (1993), Packard and Polifroni (1992), and White and Ewan (1991) questioned whether faculty members have been educationally prepared to assume the clinical teaching role. In these circumstances, teaching students in the clinical area is a most challenging professional endeavor for clinical teachers (Wong & Wong, 1987).

Tanner (1998) stated that in her 25 years of experience as a nurse educator, issues surrounding clinical teaching have been persistent in the literature and in practice. According to her, the initial struggle was to help students to apply theoretical knowledge to practice, to improve interaction between student and clinical teacher, to strengthen students' critical-thinking skills, and to evaluate nursing students objectively. Tanner reported that clinical teaching has progressed over the years. Earlier clinical experience was confined to the hospital, but now nursing students are scheduled for community experience. In addition, mentors and preceptors assist clinical teachers in the clinical experiences. Clinical teaching is developing, but because of its magnitude and complexity, there has been insufficient current research to address the issues. In addition, variation in context and differences in clinical teachers' preparation may impair the application of the research findings in a given situation. Performance in a clinical setting is the critical measure of whether or not a student can become a safe, effective nurse: "Students and faculty perceive success in the clinical arena as the ultimate test of knowledge and skills" (Infante, 1975, p. 141). An effective nurse must therefore apply highly complex didactic learning to diverse client situations; being able to recite the information is not enough.

In a recent research article Wellard, Williams, and Bethune (2000) described the education-practice relationship and provided a historical overview of nursing education in Australia. According to authors in the 20th century, nurse teachers in Australia were employed for classroom and clinical education. An apprenticeship model was implemented in which nurses were employees of the hospital. After World War II the focus of nursing education changed and moved from a clinical base to more classroom learning, and learning rather than providing service became a priority (Peterson & Schaffer, 2001). This changed the focus of nursing educators to research and scholarship. Ludwick, Dieckman, and Herdtner (1998) stated that clinical teaching was considered to be time consuming, with little academic reward. From this perception the roles of mentors, contract teachers, preceptors, and sessional instructors emerged in nursing education. In addition, cuts in funding in the health and education sectors affected the delivery of nursing education in schools of nursing (Wellard et al., 2000).

In a study in the United Kingdom, Pfeil (2003) explored the quality of teaching skills provided to nursing students from the middle of the 19th century to the late 20th century. During this period clinical teaching was in the hands of ward sisters, whose primary focus was patient care rather than teaching nursing students. Karadag and Addis (2003) looked into the role of staff nurses in Turkey in enhancing student learning in the clinical area and discovered that staff nurses were most effective in providing patient care and helping students to adjust to a clinical environment. However, staff nurses were the least effective in discussing patients with students and evaluating the patient care that the students provided. The staff nurses' reasons for this behavior were that they were overloaded with work, there was a lack of equipment, and the students worked too slowly and hence wasted the staff nurses' time.

Definition: Clinical Supervision and Clinical Teaching

Clinical supervision is viewed as a complicated process that requires the integration of many skills. Clinical supervision is a practice that has not been addressed sufficiently in the nursing literature because of the high degree of uncertainty as to what clinical supervision entails. Butterworth and Faugier (1992) defined *clinical supervision* as "an exchange between practicing professionals to assist the development of professional skills" (p. 37). According to Minot and Adamski (1989), clinical supervision is "the process whereby a learner reviews with another person ongoing clinical work and relevant aspects of his own reactions to that work" (p. 23). The Department of Health ([DOH] 1993) of the United Kingdom defined clinical supervision as "a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations" (p. 12). Inherent in such definitions is the notion that clinical supervision involves helping others to develop the necessary skills for safe and competent nursing practice. In other words, clinical supervision involves supporting learners so that they can share clinical, organizational, developmental, and emotional experiences with other professionals in a secure and confidential environment.

According to the United Kingdom Central Council (UKCC) for Nursing, Midwifery, and Health Visiting (1996) guidelines, clinical supervision is related to both personal and professional growth. O'Shea and Parsons (1979) investigated what constitutes effective clinical teaching, which they defined as instruction that occurs in settings and situations in which the student gives direct care to real clients as part of a planned learning activity. Thus, effective teaching is defined as the actions, activities, and verbalizations of the clinical teacher that facilitate student learning in the clinical environment. Ineffective teaching, on the other hand, is characterized by actions, activities, and verbalization that interfere with student learning in the clinical setting. Both Carr (1983) and Smythe (1993) defined clinical teaching as a circumscribed period in which teacher and student exist in a relationship within a common environment. The teacher's role in this relationship is to support, assist, and guide students in the assimilation of nursing knowledge. Pugh (1980), a clinical teaching researcher, argued that although clinical teaching is essential to nursing and integral to professional education, there is still a need for a greater in-depth analysis of what *clinical* means. The clinical setting is a highly unpredictable environment where a variety of events take place daily; it is also complicated with a number of political, emotional, and social dimensions. In this setting these dimensions can result in constraint; on the other hand, they have also facilitated students' learning (Packard & Polifroni, 1992; Tanner, 1994; White & Ewan, 1991). It has been suggested that this complexity of the clinical environment has impeded the unmasking of the richness of what clinical teaching has offered to nursing knowledge (Benner, 1984; White & Ewan, 1991). Thus performance in a clinical setting is the critical measure of whether or not a student can become a safe and effective nurse.

Different aspects of clinical teaching have been investigated to some degree over time. Some of these investigations have resulted in practical solutions, whereas others have offered conceptual approaches to clinical teaching. The theory for clinical teaching was drawn from classroom instruction and educational psychology, and little of it was specifically geared to concerns in the clinical settings (Lyth, 2000; Watts, 1990). Infante (1975) indicated the difficulty in nursing education of identifying the process of clinical teaching. In 1985, 10 years later, a second edition of Infante's book was published in which she recognized the importance of improving the quality of nursing education. Thus, the major area of focus in the second book was on curriculum changes such as identifying and arranging the content and sequencing. New teaching methods were suggested for the implementation of the curriculum; however, most focused on classroom rather than clinical teaching.

Historical Perspective on Clinical Practice in Nursing Education

This section addresses selected aspects of the history of clinical teaching. In 1860 the Nightingale Training School for Nurses opened in conjunction with St. Thomas' Hospital, which was based on theoretical education and supervised clinical practice. According to Christy (1980), clinical practice is a function of nursing education, although the role and responsibilities have changed over time. During Florence Nightingale's period an educational value was placed on clinical practice in the program. The nursing curricula in the 1860s reflected the concept of nurses' being perfect in activities that they perform (skills). Therefore, a skill guide was formulated that listed some 800 skills, and the goal of nursing education was to produce a professional nurse competent in providing those services to patients who required care in the hospital and community (Lindeman, 1989). Nightingale emphasized the school's autonomy from the hospital, which demanded three requisites: (a) the school had to be an independent educational institutional, (b) it had to have its own independent funds, and (c) it had to have its own board of trustees. The Nightingale system saw the appointment of a matron who performed the dual roles of caring for patients in the hospital and educating students at the school. This position reflected Nightingale's beliefs in collaboration between nursing education and service. Practice in the wards was conducted according to an apprenticeship model under ward sisters, who were paid by the hospital, with an additional financial benefit for teaching. The teaching emphasis was on helping nursing students to develop skills in how to observe, what to observe, how to think, and what to think. Teaching methods included ward teaching, case study, and the use of procedure sheets in medical surgical settings. Clinical sites for practice in the hospital were selected on the basis of relevance to the educational program rather than patient-care needs.

The Nightingale system of nursing education was established in three hospitals in the United States in 1873 (the Connecticut Training School, the Boston Training School, and the Bellevue School). The educational component inherent in the system was soon discontinued as the hospitals realized the potential for nursing schools to provide care for the sick. Most of the schools were established for economic purposes, and educational objectives became secondary. The mode of clinical education focused on trial and error rather than on a scientific or structural approach. This period was known for apprenticeship learning in nursing education, but there was no one under whom students could serve as apprentices; fellow students and seniors nurses offered learning instruction in the hospital. This changed the emphasis of clinical teaching from education to service and had a profound impact on the development of the clinical field as a learning environment.

Carper (1978) noted the inequities in nursing programs, particularly in relation to the overuse of clinical practice. Assignments to the clinical areas changed and were based on patients' needs rather than the learner's needs. Patients' health care demands were a priority over students' learning. This practice continued even though educational programs were developing. It was not until the United States federal funding in nursing education came through the Cadet Corp in 1957 that the role of the clinical setting changed because the criteria for schools of nursing to receive grants required upgrading of schools, and funds were made available for faculty development.

Nursing education in Canada has evolved over the years. The first school of nursing established on the Nightingale model in Canada was St. Catherine's Training School, established in Ontario on June 10, 1874, by Dr. Theophilus Mack (Ross-Kerr & McPhail, 1991).

In the 19th century the apprenticeship system was practiced in nursing education, which created concerns among nursing leaders about the standards of education. Consequently, after achieving nursing registration in the 1920s and 1930s in each province, nursing leaders became concerned with setting a higher nursing education standard. This was attained through developing a standard curriculum with the objective of providing a strong, foundational nursing education in the country. In 1932 Dr. George Weir reported the results of the first national study to explore the existing nursing education system in Canada (Ross-Kerr & McPhail, 1991).

The first university degree program in nursing in Canada began at the University of British Columbia in 1917. From 1940 to 1955 education in nursing became firmly established at a number of universities and began to accommodate increasing numbers of students. The report of the Royal Commission on Health Services (1964; as cited in Ross-Kerr & McPhail, 1991) was to change university nursing education. It recommended establishing 10 more university nursing programs in Canada, expanding the availability of baccalaureate programs in the country, and moving diploma programs to mainstream educational institutions. Following the Royal Commission report, most of the hospital schools in Canada were closed, and nursing moved to colleges. This was also a period of growth in the university programs.

With this change in the educational system, nursing practice began to develop with its own theoretical base and more emphasis was placed on the academic linking of schools of nursing with universities. The practice sites were chosen based on learners' needs, and skilful clinical teachers provided the learning instruction.

Models of Clinical Teaching

Currently, there are three primary models of clinical teaching: (a) the clinical teacher model (traditional model), in which the academic faculty are directly responsible for guiding students' learning in the clinical setting; (b) the preceptorship model, in which clinical teaching is conducted by associates, those in the clinical setting provide clinical instruction, and the clinical teacher (academic) is responsible for the overall planning, coordinating the experience, and grading the clinical practice of nursing students; and (c) a combination of the traditional and preceptor models that includes the use of clinical teachers or preceptors with clinical teachers, depending on the type of course.

The Clinical Teacher Model

In the clinical teacher or traditional model of clinical teaching, the academic faculty are responsible for facilitating nursing students' clinical experience and are present in the clinical area (Nehls, Rather, & Guyette, 1997). In this approach the ratio of clinical teacher to nursing students ranges from 18 to 35 students per clinical teacher in most of the nursing schools in Pakistan, whereas it ranges from 8 to 10 in countries such as Canada and the United States. This model provides an opportunity to assist students in integrating the concepts and theories learned in class into clinical practice with real patients. Thus, the clinical teacher selects clinical activities that best meet each student's learning needs and are consistent with the course goals and objectives. In this approach large numbers of nursing students are supervised by one nursing clinical teacher, and therefore the clinical teacher may not be accessible to the students all the time. This model thus requires an increased time commitment from the clinical teacher (Nordgren, Richardson, & Laurella, 1998).

The advantage of this model is that the clinical teacher does not take a patient load and can focus his/her entire attention on teaching. A disadvantage of the traditional approach is that the clinical teacher may lack competence in the clinical skills because of the rapid technological changes that are occurring in health care (Paterson, 1997). The clinical teacher and nursing students in this model are not part of the system of care; they represent, according to Paterson, a temporary system within the permanent culture of the clinical setting. Therefore, the clinical teacher and the nursing students often consider themselves as strangers, and they may also be seen as strangers by the nursing staff. The time required for planning the clinical experience and evaluating nursing students' learning is enormous. In this model the working relationship between the faculty and the staff is critical in creating an environment conducive to learning.

The Preceptorship Model

The preceptorship model has gained popularity in nursing education. *Preceptorship* may be defined as "an individualized teaching/learning method in which each student is assigned to a particular preceptor . . . so the nursing student can experience day to day practice with a role model and resource person immediately available within the clinical setting" (Chickerella & Lutz, 1981, p. 107). In this model a staff nurse works with the nursing student on a one-to-one basis for a specified time in the clinical setting. It is believed to be an effective way of providing individualized guidance to nursing students. In addition, it provides opportunities for socialization (Kersbergen & Hrobsky, 1996; Stokes, 1998).

Preceptors are staff nurses who, in addition to their patient care, take on the responsibility for providing onsite clinical teaching to assigned students. A faculty member acts as a liaison person between education and practice (Nehls et al., 1997). Thus, in the preceptor model the clinical experience is linked among three members: the nursing faculty, staff nurses from the clinical settings, and the nursing student. The preceptor is involved in the evaluation of the nursing student, although the academic teacher has final responsibility for the summative evaluation.

Preceptors have primarily been used for senior nursing students, graduates students to help them to prepare for advanced-practice roles, and new staff orientation (Myrick, 1991). They have also been used effectively with beginning nursing students

(Kersbergen & Hrobsky, 2002; LeGris & Cote, 1997; Nordgren et al., 1998; Stokes, 1998).

There are limited research findings on the effectiveness of the preceptor teaching model. Myrick (1998b) studied the relationship of preceptorship and critical thinking in nursing education. The purpose of this grounded theory study conducted in Canada was to examine the process used in preceptorship to develop and promote the critical-thinking ability of basic baccalaureate nursing students. The participants were fourth-year basic baccalaureate nursing students and their preceptors. Myrick observed the preceptors and preceptees as they worked together and conducted semistructured interviews. The findings indicate that the process that occurs in preceptorship to develop and promote critical-thinking ability is a process of 'enabling.' It is related to the interpersonal process in which the preceptor provides the preceptee with the opportunity to develop and promote critical thinking in the practice area.

Gaberson and Oermann (1999) reported study results that show no difference in students' performance between those assigned to preceptors and those who worked with clinical teachers in the clinical setting. However, Stokes' (1998) research indicated that final-year students who were assigned to preceptors reported satisfaction with regard to increased confidence and independence in patient care. As well, the presence of nursing students in the clinical environment enhances the professional development and teaching skills of preceptors (LeGris & Cote, 1997). Some of the drawbacks to this model are that preceptors may be unavailable because of increased patient acuity and that they may lack knowledge on the integration of theory, research, and practice into teaching. Even though preceptors may be skilful and expert in a practical situation, they may lack capability in teaching nursing skills. In some situations where there is regular staff turnover, it may also be difficult to find preceptors with sufficient levels of expertise. In such cases preceptors are relative neophytes who have limited experience and less expertise than desired. In addition, potential preceptors may simply refuse to take additional responsibility because of increased workloads (LeGris & Cote, 1997; Nordgren et al., 1998).

The success of the preceptorship relationship largely depends on the selection of the preceptors. It is therefore important that preceptors who are selected have the desire to teach and a willingness to serve as preceptors. Some of the positive attributes of preceptors include clinical expertise, leadership abilities, teaching skills, and professional role behaviors and attitudes (Bain, 1996; Davis & Barham, 1989; Myrick, 1998a; Stokes, 1998).

Different versions of preceptorship models exist in nursing education. One example is the clinical teaching partnership model. It is similar to the preceptorship model but is concerned more with advanced or specialized skills in nursing practice.

Mentorship uses similar principles to those used in the preceptorship model; the difference is in the relationship with nursing students and the time duration (Reilly & Oermann, 1992). The concept of mentorship was first introduced within the academic and business worlds of North America, and it became a vital tool in preparing these professionals (Northcott, 2000). With the commencement of Project 2000 in the UK, mentors were utilized for clinical teaching (Phillips, Davies, & Nearly, 1996). They worked on the wards to facilitate learning and prepare nursing students to take up the professional role (Andrews & Roberts, 2003).

Suen (2001) conducted a study to explore students' perceptions of effective mentors in an undergraduate nursing program in Hong Kong. This was a multiphase study that used a quantitative approach. Students' perceptions on various mentors were collected using a tool called the Honorary Clinical Instructors scheme (HCI scheme). The mentoring scheme was evaluated in semester 1, which resulted in a series of strategies designed to improve the preparation of the mentors, and the scheme was implemented again in the next semester. The mean difference of 8.69 statistically signifies a positive difference in the study outcomes after the strategies were implemented. The tool is now used to evaluate the effectiveness of mentoring programs in the US.

Combination of the Clinical Teacher and Preceptorship Model

In this model, at the beginning of the nursing program clinical teachers accompany nursing students for their clinical experience. Once the nursing students have acquired basic nursing skills and progressed in the program, the clinical experience is facilitated by preceptors. The advantage of this approach is that nursing students in their early professional experience receive guidance from clinical teachers who have expertise in teaching and learning, and later on, at the stage at which they are expected to become more independent, they are assigned a preceptor. Thus, preceptors facilitate the integration of theoretical knowledge into practice. The University of Alberta uses this approach to facilitate students' clinical experiences.

It is important to understand the different clinical teaching models, because no one model can entirely meet the learning needs of all nursing students. Some considerations to keep in mind in selecting a clinical teaching model are the educational philosophy of the school of nursing, the objectives of the clinical courses, the availability of clinical teachers and preceptors, and the characteristics of the nursing students.

The Clinical Teacher

The roles of the clinical teacher have proven to be diverse (Clifford, 1993; Crotty, 1993; Diekelmann, 1990; Lee, 1996). Clinical teaching entails multiple roles that require the ability to guide students in unpredictable settings. In other words, in contrast to the classroom, where teachers have a great degree of control, clinical settings offer far less opportunities to control the environment. Research studies prevail on the characteristics of the effective clinical teacher. Many terms are used in nursing education to describe the role of clinical teacher: *assessor*, *mentor*, *preceptor*, *nurse tutor*, *nurse educator*, *link teacher*, *supervisor*, *clinical faculty*, and *clinical teacher*. To avoid complicating the terminology for this study, the above terms will all be used to mean clinical teacher. Phillips et al. (1996) conducted a study in which they demonstrated that even though multiple roles are played in teaching and assessing nursing students, the literature failed to provide a clear description of each role, which creates uncertainty about role expectations.

What are the characteristics of the effective teacher? Clinical teachers guide students in applying theory to practice. Clinical teachers are expected to be competent, experienced, knowledgeable, flexible, patient, and energetic (Bradshaw, 1997). They can promote and discourage learning in the clinical area; hence, it is important to explore the characteristics of effective clinical teachers. Irby (1994) defined effective clinical teachers as those who possess a rich knowledge base, but can also transfer their knowledge for teaching purposes.

The nursing literature described what could be considered themes that characterize effective clinical teaching, such as having good clinical knowledge (Benner, 1984; Christy, 1980; Clifford, 1993), being supportive (Bergman & Gaitskill, 1990; Brown, 1981; Marcinek, 1993), and providing a positive learning environment (Flagler, Loper-Powers, & Spitzer, 1988; Gross, Aysse, and Tracey, 1993; Kushnir, 1986). What is missing in this literature is a description of the process whereby clinical teachers can demonstrate these concepts in working with students. For example, how clinical teachers can be supportive, motivate, evaluate, and at the same time provide a positive learning environment for nursing students is less well documented.

Thirty-eight years ago Jacobson (1966) studied effective and ineffective behaviors of nurse educators by using a modified form of the critical-incident technique with undergraduate students in five university schools in the southern United States. Six categories of effective behavior were identified: availability to students, professional competence, interpersonal relationships, teaching practice, personal characteristics, and evaluation of students. With the passage of time different studies have been conducted on the topic using different approaches. However, the basic characteristics that Jacobson identified 38 years ago remain the same. The following section classifies the characteristics of clinical teachers in three categories: knowledge and clinical competence, teaching skills, and relationship with students.

Knowledge and Clinical Competence

Clinical teachers are expected to have a rich understanding of the subjects they teach and to appreciate how knowledge in their subject is created, organized, linked to other disciplines, and applied in a clinical setting. To teach effective clinical teaching skills, clinical teacher education for nursing faculty is necessary and important. Bergman and Gaitskill (1990) explored the characteristics of effective teachers with faculty and students and identified knowledge as an important characteristic. Having the ability to analyze theories and synthesize knowledge from multiple sources, with an emphasis on promoting a conceptual understanding among learners, is an important character of a teacher (Reilly & Oermann, 1992). Teachers' theoretical and clinical knowledge and attitudes towards the profession influence teaching (Nehring, 1990). Knox and Mogan (1985) referred to this theoretical and clinical knowledge as *nursing competence*.

Clinical competence has been documented as an essential characteristic of an effective clinical teacher (Stokes, 1998). Clinical competence includes the integration of theoretical knowledge and expert clinical skills and judgment in the practice area in which teaching occurs (Nehring, 1990; Oermann, 1996; Oermann & Gaberson, 1998).

Clinical competence has been reported consistently in studies as an important characteristic of effective clinical teachers (Benor & Leviyof, 1997; Bergman & Gaitskill, 1990; Cahill, 1997; Nehring, 1990; Pugh, 1988; Sieh & Bell, 1994). Clinical teachers should maintain current clinical knowledge through participating in continuing education and practice experience (Krafft, 1998; Rudy, Anderson, Dudjak, Kobert, & Miller, 1995). The competent clinical teacher knows how to function in clinical practice and can guide students in developing clinical competencies. Girot (1993) reviewed the nursing literature on competence and found it "confusing and over defined, rather than ill defined" (p. 83). In other words, Phillips et al. (1996), Nehring, and many other nursing researchers have defined competence in their own way, which has caused confusion.

Achieving competence is not confined to nursing students, but also applies to nursing faculty.

Fourier, Oliver, and Andrew (2002) conducted a study for the Nursing Council of New Zealand (NCNZ) that looked at the guidelines for practicing nursing educators' competence. They explored the issues surrounding competence in practice and how nurse educators maintain their practice. To function as a clinical nurse teacher in New Zealand requires a certificate. Competence in the above study referred to direct patient care by those nurse educators who often do not have a patient caseload.

Another term used in nursing education along with competence is *credibility*. What is clinical credibility? According to Massarweh (1999), clinical credibility means being up to date on theoretical aspects while maintaining clinical skills and ensuring that teaching is based on current practice. This concept ensures that theoretical knowledge is supported with current practice and that current practice is based on theory and research-based knowledge (Crotty, 1993). Pugh (1988) reported that students identified the clinical teacher's ability to demonstrate nursing care in a real situation as an important behavior in clinical teaching.

Nahas (2000) examined clinical credibility in nursing teachers who taught in the postgraduate tertiary specialization program in Hong Kong. She drew attention to one of the points that the literature has been addressing for a long time, the theory-practice gap, which is the discrepancy between what is taught in the classroom and what is practiced in the clinical area. According to Nahas, this gap existed because the nurse teachers were removed from the clinical area. She further questioned whether a classroom teacher without clinical credibility can effectively teach, assess nursing students' learning, and ensure their competence in clinical skills. The findings indicate that clinical teachers need to be skilful and knowledgeable to demonstrate credibility and to enhance students' learning in the clinical area. The AKUSON faculty in Pakistan conducted a similar study (Upvall et al., 2000). The researchers explored the concept of faculty practice among clinical nursing teachers; the results suggest that the clinical teachers had no concept of faculty practice. Maintaining clinical competence and credibility is essential in assisting students in developing knowledge and skills and providing expert supervision in the clinical setting. However, the issue of clinical credibility in clinical teaching still exists.

Teaching Skills

The importance of effective teaching skills cannot be ignored in nursing education. Brown (1999) conducted a study to evaluate a 12-year mentorship program for faculty members at the University of North Carolina. The program showed a positive impact on the professional and personal development of novice faculty. Forty-four faculties served as mentors for 47 new faculty members in their first year of employment, with pairing based on mutual interest. A feedback questionnaire from both groups revealed that the program is beneficial. Brown surveyed the role of mentors in orienting new faculty to their teaching role and found that an effective clinical teacher demonstrates skills in clinical teaching that include the ability to assess learning needs, plan instruction that meets these needs, guide learning so that students gain essential clinical knowledge and develop skills, and evaluate learning objectively. Clinical nurse teachers use a variety of the skills to facilitate learning in the clinical area. For example, questioning is an integral part of the teaching role because it assists students in applying their knowledge and developing critical-thinking skills (Hartley, 1994; House, Chassie, &

Spohn, 1990; Infante, 1981; Myrick, 1991; Profetto-McGrath, Smith, Day, & Yonge, 2004; Rossignol, 1997; Wink, 1993). It is important to ask questions that reflect higher level thinking processes, such as application, analysis, synthesis, and evaluation, to promote critical thinking among nursing students (Bloom, 1956).

Numerous studies have defined and evaluated effectiveness in the clinical area (Benor & Leviyof, 1997; Brown, 1981; Knox & Mogan, 1985; Mogan & Warbinek, 1994; Nehring, 1990; Reeve, 1994). Some of these studies resulted in the development of instruments to evaluate faculty effectiveness in clinical settings; however, none addressed strategies to improve teaching in clinical settings. Karuhlje (1986) found that 78% of 211 nurse educators who participated in the study indicated a lack of information on clinical instruction in their graduate education. The nurse educators suggested including content such as clinical teaching strategies, evaluation of students' clinical performance, and the development of clinical evaluation tools and clinical teaching practicum for experienced teachers. Good teachers have knowledge of the subject, are well organized, emphasize important points during teaching, clarify ideas and point out significant relationships, motivate students through their teaching practices, and pose and elicit useful questions (Eble, 1988). Flagler et al. (1988) found that giving positive feedback was most valuable in helping students to develop self-confidence as a nurse; giving negative feedback hindered students' development of self-confidence in clinical practice.

Krichbaum (1994) explored the relationship between 24 behaviors of preceptors who were supervising baccalaureate students in the clinical setting. The preceptors' use of clinical teaching behaviors was assessed by the preceptors themselves and by students.

Student's clinical performance was related to their preceptor's teaching skills. The study looked into the ability of the preceptor to adapt to the needs of the students. Krichbaum considered it critical to structure clinical activities for students, find opportunities to observe other nurses asking appropriate questions, and give feedback to the students.

Students have consistently reported the importance of the clinical teacher being knowledgeable and able to share that knowledge and expertise with them as they care for the patients (Benor & Leviyof, 1997; Bergman & Gaitskill, 1990, Nehring, 1990; Pugh, 1988). There are four requirements in nursing knowledge: (a) understanding concepts and theories for patient care, (b) assisting students in using concepts and theories to understand patients' health problems, (c) being up to date on nursing interventions and how they might be used in the care of patient, and (d) using this clinical knowledge to help students arrive at sound decisions about patient care (Hsu, 2000).

One of the major issues that the clinical teachers identified is the lack of formal instruction in clinical teaching, which thus requires that they rely on their own experiences (Fitzpatrick, 2001; Meleca et al., 1981). Bachman, Kitchens, Halley, and Ellison (1992) reported that new educators frequently feel uncertain, afraid, and frustrated because they have limited preparation for the teaching role. As a result, most nurse educators do not change or modify their teaching concepts during clinical teaching. They learn clinical teaching by using trial and error methods or by observing experienced faculty in the clinical setting. Lee (1996) conducted a factor analysis of the clinical teaching characteristics of 87 nurse teachers and 623 nursing students in an associate program in Taiwan and found that the faculty preferred faculty development programs on clinical situations to improve the quality of their teaching.

Clinical teaching is influenced by educational philosophy, one's belief and values about a nursing model of education. Philosophy helps to develop a personal framework for practicing nursing to be effective clinical teachers. Kiker (1973) identified professional competence as a characteristic of the effective teacher and indicated the required teaching behaviors, but failed to explain the development of those characteristics. Thus, clinical teachers are expected to be effective, but Kiker did not specify how to do so. There is a lack of research on how clinical teachers learn to teach.

Pfeil (2003) stated that clinical teaching in nursing is a complex phenomenon and lacks a coherent theoretical base. Different research studies carried out in clinical teaching examined clinical teaching styles. In their doctoral theses, Buckley (1990), Carr (1983), Kinney (1985), and Paterson (1997) concurred that the clinical area is a complex, changing, and challenging teaching/learning situation. They gave useful descriptions of what actually happens in clinical practice and identified the complexities of the clinical teaching environment and the role of the teacher who must manage that environment. Buckley supported the concept of the changing nature of clinical teaching and answered the question of why many clinical teachers and nursing students find planning and implementing clinical learning activities difficult. However, the authors of these theses did not propose any theory development in nursing education.

Hsu (2000) developed a curriculum model for the improvement of clinical teachers in Taiwan. The author contended that little attention has been paid to nurse educators' preparation for clinical teaching. The purpose of this study was to develop a curriculum model for nurse educators to enhance the quality of their teaching and to evaluate the effectiveness of the module. Ten clinical teachers participated in a nine-day workshop and assessed the effectiveness of the curriculum model through clinical-teaching questionnaires, course-evaluation forms, and participant-observation methods. The nurse educators exhibited a broader knowledge base on clinical teaching, but the issues related to the implementation of the curriculum model were not addressed.

Woo-Sook, Krystyna, and Wilson (2002) investigated nursing students' and clinical educators' perceptions of the characteristics of effective clinical educators in an Australian university school of nursing. This study replicated the research study that Knox and Mogan conducted in 1985 in which they investigated and described the characteristics of the 'best' and 'worst' clinical educators. They used an instrument known as the Nursing Clinical Teacher Effectiveness Inventory (NCTEI) to collect data in five categories: teaching ability, interpersonal relationship, personality traits, nursing competence, and evaluation. This tool has been used in several countries, including Greece, Hong Kong, and North America. The aim of Knox and Mogan's study was to explore the perceived characteristics of effective clinical educators as rated by students and educators. The results indicate that the category of interpersonal relationship was the most highly valued by both Australian students and educators. Although there were no significant differences between the two groups, students were more concerned with evaluation, whereas clinical educators were more concerned with nursing competence.

Students rated the following five categories of effective clinical educators' characteristics: teaching ability, mean (M) = 4.05, Standard Deviation (SD) = 0.87; interpersonal relationship, M = 4.15 , SD = 0.77; personality traits, M = 4.02, SD = 0.87; nursing competence, M = 4.08, SD = 0.87; and evaluation, M = 4.11, SD 0.82. Clinical educators rated the above five categories as follows: teaching ability, M = 4.00, SD = 0.67; interpersonal relationship, M = 4.13, SD = 0.80; personality traits, M = 3.932, SD = 0.74; nursing competence, M = 4.10 , SD = 0.74; and evaluation M = 4.08 , SD = 0.87.

A tool used in the Stanford Faculty Development Program is a valid and useful means of analyzing the teaching process. This educational framework contains seven categories: establishment of a positive learning climate, control of the teaching session, communication of educational goals, promotion of understanding and retention of knowledge, evaluation of the learner, provision of feedback to the learner, and promotion of self-directed learning (Callister, 1993; Craig, 1991; DeTornyay, 1990; Melia, 1987; Skeff, Stratos, Berman, & Bergen, 1992).

Clissoid (1962) contended that nursing has offered little guidance to the new teacher. Educational programs focus on the school policy, curriculum content, or nursing procedures, which is of little help to clinical teachers in developing skills. Smith (1977) looked into issues such as assigning credit for clinical work, handling student complaints, and issues affecting clinical teacher; however, Clissoid offered little information on teaching behaviors appropriate to clinical teaching. Only in recent years have instructors in professional schools such as medicine, dentistry, and nursing begun to study the educational process in the clinical setting (Daggett, Cassie, & Collins, 1978). Because of the limited research on clinical instruction, there is a lack of specific preparation for clinical instruction in all of the health-related disciplines (Beck, Youngblood, & Stritter, 1988; Christy, 1980).

Karuhije (1986) reported on clinical instructors' perceptions of preparation for clinical instruction. The participants included volunteers who were attending the National

League for Nursing (NLN) Convention in Philadelphia in 1983. They returned 211 questionnaires, and 78% agreed that most graduate programs do not provide basic information on clinical instruction.

Relationship With Students

Several researchers analyzed the characteristics of a positive relationship between clinical teacher and students in the clinical area. Pesult and Williams (1995) found that psychiatric clinical nurses described a good clinical teacher as providing specific ideas and feedback, promoting autonomy, and demonstrating warmth and competence. In another study Sloan (1998) saw being supportive, knowledgeable, and committed to providing supervision as critical. What is common in these studies is that being able to identify the learners' perceived knowledge and skills is an important aspect of effective clinical teaching, but that having humanistic attributes such as caring and respect for individuals is just as important.

Kuen (1997) conducted a research study on the perceptions of effective clinical teaching in a hospital-based nurse training program in Hong Kong, where she examined student nurses' (n = 81) and nurse educators' (n = 10) perceptions of effective clinical teaching behaviors of nurse educators in a hospital-based three-year general nurse training program. Knox and Morgan's (1987) Nursing Clinical Teacher Effectiveness Inventory (NCTEI) was utilized, and the respondents were asked to rate the importance of each behavior on a 7-point scale. The analysis of the data for nursing students and nurse educators revealed a range of mean scores for the five behaviors ranking from the highest, 'evaluation,' M = 6.04, to the lowest, 'nursing competence,' M = 5.77. For the clinical educators, the highest ranked item was 'evaluation,' M = 6.13; and the lowest ranked items was ‘teaching ability,’ M = 5.91. The t-test revealed that there was no statistically significant difference in the five behavioral categories between the perceptions of students and those of nurse educators.

Furthermore, the clinical teachers believed that their role in practice is important but that there are significant forces that impede their ability to move with ease between education and practice. These forces are related to the ward environment in which a clinical teacher is considered an ‘outsider’ with no influence on the organization of the ward’s functioning. Having a standard measure of clinical educators’ characteristics is useful in establishing relevant clinical teaching behaviors. Established set behaviors, it is hoped, will promote greater role flexibility and greater learning in clinical settings (Kanitsaki & Sellick, 1989; Loacker, 1988).

In a qualitative study conducted in New Zealand, McClelland and Williams (2002) looked at third-year students in their final year of the nursing program. They examined the factors that impinge upon students’ learning experiences and conducted individual interviews and focus groups. The themes that emerged in the study were powerlessness, marginalization, and exploitation of minority students. Clinical experience was normally positive, but each student had had a negative experience in the clinical that was related to the clinical teacher’s workload and the fact that the clinical teacher was not always available in the clinical area. These experiences created a sense of powerlessness and marginalization among the nursing students. The Maori (minority group) students felt exploited because their voice was not heard. The students were also concerned about the lack of time to debrief at the end of a stressful clinical day. Hence, apart from possessing good knowledge and teaching skills, a clinical teacher needs to demonstrate "humanistic" attributes.

Lee (1992) conducted a study in Taiwan with 87 faculty members, 436 nurses, and 623 nursing students from associate degree nursing programs and listed 36 clinical teaching characteristics. The results indicate that the faculty ranked relationship and personal attributes as the most important characteristics, and the students ranked fair and objective evaluation and professional competence as the most important characteristics. In addition, among the three groups, the students were the most dissatisfied with the quality of the clinical teaching. Thus, after four years, Lee (1996) used ex post facto research to examine the problems of clinical practice in a five-year junior-college program in Taiwan. She reviewed the evaluation forms for four years and identified approximately 1,675 problem units. Overcoming the issues of the theory-practice gap and the lack of fair, objective evaluation was most often a problem for faculty.

Nursing education repeatedly asks, "Why are some clinical experiences better than others?" (Massarweh, 1999). Andrews and Roberts (2003) suggested that supporting nursing students in learning is an important function; however, there was little consensus in the literature on what constitutes appropriate support and which methods promote learning. In response to the above concerns, University of Salford developed a clinical guide, as documented in the report *Fitness for Practice* (UKCC, 1999b). The UKCC suggested promoting positive clinical experience by motivating students, encouraging the use of critical thinking, and strengthening total quality management.

The Process of Clinical Teaching

A shift to higher education and striving for academic excellence has inadvertently denounced the credibility of nursing education in the clinical setting and has cemented the belief that those who teach differ greatly from those who practice (Clifford, 1996; Glossip, Hoyle, Lees, & Pollard, 1999). Are these perceptions true? They require further exploration. The following section describes the process of clinical teaching, which includes five steps: identifying the goals and outcomes for learning, assessing learning needs, planning clinical learning activities, guiding students, and evaluating clinical learning performances. The nursing process has the following steps: assessment, planning, implementation, and evaluation.

In the literature search I found only one study on the process of clinical teaching. Dickson (2001) used a qualitative approach to describe the process of teaching and learning through the experiences of five novice and five expert clinical teachers. The findings indicate that clinical teaching involves seven interactive components: the process through which clinical teaching is learned, experiences as a student, experiences as a nurse, experiences as a clinical teacher, experiences with others, experiences with other clinical teachers, and feedback on clinical teaching. Dickson explored the difference between two groups with varying experiences as clinical teachers. Analysis of the data indicated that the experiences of novice and expert clinical teachers appeared similar; however, conceptualization differed based on the experience. One may reflect on the questions, What makes a clinical teacher an expert? Is it the number of experiences, knowledge, and/ or skills? General experience indicates that it is not necessarily the number of years of experience that make a person an 'expert' (Benner, 1984), but rather, specialized knowledge of a domain (Patel & Groen, 1991). In many domains, including nursing and medicine, expertise develops over the years of practice and experience (Benner, 1984; Benner, Tanner, & Chesla, 1996; Ericcson & Smith, 1991). Benner et al. explained:

> The practice of the expert . . . is characterized by engaged practical reasoning, which relies on mature and practiced understanding, a perceptual grasp of distinctions and commonalities in particular situation, . . . and increased intuition links between seeing the salient issues in a situation and ways of responding to them. . . . With expertise comes fluid, almost seamless performance. (p. 143)

Interesting information that Dickson (2001) presented is the use of mental processes such as reflection to connect experiences with the teaching outcome. Clinical teachers were unable to explain the role of the mental process in the development of their expertise, but they were aware that they had developed an intuitive knowledge of the teaching experience. Once the clinical teachers developed expertise, they trusted their intuition. They wanted to know whether it is acceptable to rely on intuition in assessing a nursing student's performance. In response, Dickson suggested that novice clinical teachers use structural strategies in the clinical setting.

Components of Clinical Teaching

Assessment

Since the 1980s the emphasis of nursing education has been on measuring the performance of nursing students. Nursing teachers and schools must be accountable for the outcomes of their educational efforts (Dillard & Laidig, 1998). *Outcomes* in this context refer to the characteristics, qualities, and attributes that a nursing student demonstrates at the end of the educational program. Planning for clinical teaching thus begins with identifying learning outcomes that are necessary for safe, competent nursing practice. These include knowledge, skills, and professional attitudes and values that are structured from a mission statement. In the clinical the knowledge learned in the classroom is put into practice. Knowledge outcomes include the use of cognitive skills in the form of problem solving and critical thinking. *Skills* refer to psychomotor skills, which are movement-orientated skills that involve an overt response that requires neuromuscular coordination (Reilly & Oermann, 1992). Clinical learning also has important outcomes with regard to attitudes and values that represent humanistic and ethical views. Because of their complexity, it is difficult to measure these attributes.

Nursing students are assessed in the following steps. The assessment begins with identifying the learning goals and outcomes of the clinical experience. These goals and outcomes suggest areas for assessment that provide guidelines for teaching and are the basis for evaluation. The learning outcomes are often called the clinical *objectives* or *competencies*. The objectives specify the acquisition of knowledge, the development of values, and performance of psychomotor and technical skills. Clinical objectives address eight areas of learning (Oermann & Gaberson, 1998): (a) the application of knowledge, concepts, and theories to clinical practice; (b) the use of critical thinking in assessment, diagnosis, planning, intervention, and evaluation of patient care; (c) demonstration of psychomotor skills; (d) the affective domain or values related to patient care; (e) the ability to develop interpersonal skills; (f) management skills with regard to care; (g) accountability and responsibility as a learner; and (h) a self-developmental approach. It is critical to assess students' current level of knowledge and skills because most students who enter nursing have a wealth of life experiences.

It is essential that the clinical teacher take these objectives into account to enhance learning. Clinical courses tend to have prerequisite courses, and each student internalizes the prerequisite content in a different manner based on past experience and learning opportunities. The purpose of assessment is therefore to identify the point at which instruction should begin, and this may vary from student to student.

Dolan (2003) conducted a study in Glamorgan to evaluate the assessment system. She collected data from four institutions by using qualitative and quantitative methods and involved a total of 226 participants. In focus-group discussions she asked students, preceptors, and tutors for their views on the current assessment system. Six themes emerged from Dolan's study; two related to the current study were inconsistency and the time allocated for assessment. Inconsistency concerned the way that assignments were interpreted and the length and number of materials required to be submitted for evidence. The entire group in the study found it difficult to find sufficient time for the assessment. Limited work has been done on the number and type of clinical assessments in nursing education. In most situations, clinical teachers are unaware of the guidelines available for clinical courses because insufficient literature is available for clinical courses.

Having groups of 14-20 students in the clinical makes it difficult for clinical teachers to assess objectively; therefore the assessment tools must be concise but objective enough to assess learning needs. Considering the Pakistani system, in which clinical teachers are not expected to be present with the students in the clinical area, assessing students' performance objectively becomes even more critical. The time required for planning the clinical experience and evaluating nursing students' learning is enormous.

Assessment of nursing students' competence in clinical practice is an issue that students and clinical teachers have discussed in the literature and in practice. Assessments must be well planned and structured, with a clear definition of the objectives to be achieved. Gaberson and Oermann (1999) remarked that "varying assessment strategies provides a broader database for judging student performance" (p. 65). Some students are able to clearly identify the integration of their knowledge and skills in their practice, which can be assessed through observation and verbal communication. Other students are better at articulating their learning through written work.

Wilkinson (1999) suggested ways in which nursing students can be assessed in the clinical area. One requirement is that clinical teachers know the students' learning objectives to facilitate their achievement. It is critical that the assessment be continuous. It is also vital that clinical teachers not form impressions on the first day of the clinical, but rather to assess students over a period of time to gain a true picture of their performance. First impressions must not unduly influence the assessment. Assessing the nursing student within the given time period in the clinical area is difficult because of a number of variables that are difficult to control, and clinical teachers should rely on their own critical judgment of the performance of the nursing students. However, if a clinical group is large, there is a possibility that nursing students who perform at a low level will be missed. Roentree (1987) advised making the assessment reliable and valid. Therefore, it is important that clinical teachers be aware of the assessment tools used in institutions and their implications for students. Nursing students require cognitive, psychomotor, and affective preparation for clinical learning activities, and it is the clinical teacher's responsibility to assist them with such preparation and monitor their readiness.

Readiness for clinical learning includes having information about the learning objectives, the clinical agency, and the role of the clinical teacher and staff member. Skill learning is an important outcome of clinical teaching. To learn complex skills, students should be given the opportunity to practice in a laboratory on simulated patients to gain confidence before using their skills with real patients. Affective preparation includes learning strategies to manage student anxiety and foster confidence and positive learning. Most students experience anxiety about clinical learning. Therefore, it is important that clinical teachers plan the orientation to the facility (placement), which includes providing information about the location and physical setup, the agency policy, daily schedules and routines, procedures for responding to emergency, and documentation of patient information. In addition, the clinical teacher should reveal the clinical learning expectations for the course to make nursing students aware of the process for assessment and evaluation.

Researchers such as Wooley (1977) have for a long time recognized clinical assessment as a challenge in nursing education. Dolan (2003), in her article "Assessing Student Nurse Clinical Competency: Will We Ever Get It Right?" identified the assessment of nursing students in clinical practice as a longstanding and difficult problem. Clinical teachers may provide guidelines for observing students, but it is critical that they examine their own values and attitudes first. They need to be open to discussing observation with students and obtaining their perceptions and be willing to modify their judgments when a different perception is presented (Oermann & Gaberson, 1998). Apart from observing, a clinical teacher needs to ask questions that promote critical thinking in students. Asking stimulating questions allows the clinical teacher to access the learning of the learner.

Observation

Assessment requires objective observation. Wood (1982) saw assessment as dependent upon the observation of the learner's performance by another, which is prone to subjectivity. Wood suggested using various approaches to assessment to provide students with an opportunity to reflect on the learning aspect. This brings another question to mind: Do all learning outcomes have to be evaluated? When does the learning process stop and evaluation begin? On the same issue, Benner and Tanner (1987) believed that nursing is an art and a science that require scholarly learning. They proposed that intuition is a fundamental facet of an expert clinical assessment schedule. During clinical teaching, when teachers have made reasoned judgments of students' clinical competencies, they draw from self-critiques of their expertise and personal knowledge of nursing practice and education (Friedman & Menin, 1991; Girot, 1993; Paterson, 1997).

Paterson and Groening (1996) contended that the conscious and unconscious subjective responses of clinical faculty have an impact on the practice of the teacher-evaluator role. I question how an abstract concept such as intuition can be assessed objectively. Novak (1988) also discussed the difficulties encountered in measuring abstract qualities that are fundamental to practice and argued that the inability to measure such qualities means that nursing educators fail to illustrate the difference between a nurse who is proficient in terms of practical skills and one who is skillfully competent, empathetic, and compassionate. After 1970 the UK implemented a system of continuous assessment to evaluate the practical competence of nursing students that was aimed at improving the validity, reliability, and objectivity of the assessment (Quinn, 1995). However, even with all of these efforts, issues associated with the concept of objectivity, validity, and reliability in assessment remain a concern (Girot, 1993).

Competence and struggle. Although I found literature that defined the term *competence*, it was difficult to determine how it can be assessed in nursing education (Girot, 1993). In recent years the literature has been replete with discussion papers on the difficulties of defining competence in nursing (While, 1994). However, little consensus has been reached, and clinical assessment of students continues to have its own challenges for nursing education. UKCC (1996) developed competencies for assessing nursing students' performance in the clinical area, but little is known about how these competencies should be assessed (Dolan, 2003).

In articles on assessment in nursing education, *competence* is a term that is frequently cited. What is competence? The *Oxford Dictionary* (1984) defined competence as "ability" and *competent* as "having the required ability, knowledge or authority; effective and adequate" (p. 43). The difficulty is in the interpretation of the term competence. Different researchers view it differently based on their values, beliefs, and experiences, which leads to problems with assessing competence. Butler (1978) defined competence as "the ability to meet or surpass prevailing standards of adequacy for a particular activity" (p. 51). Boss (1985) saw it as something more than mere knowledge or skills and defined a much wider concept of competence that embodies all that is fundamental to professional nursing practice. According to Benner (1984), the developmental model of expert practice includes five stages: novice, advanced beginner, competent, proficient, and expert. Miller, Hoggan, Pringle, and West (1988) proposed two understandings of competence: To be competent at performing particular skills (although this may not necessarily mean that one is a competent nurse per se) indicates competence, or one may be attributed a quality described as competence, which Miller et al. defined as a "state of being" (p. 213). One definition has characteristics that are distinct from the other.

Planning Clinical Learning Activities

After assessing nursing students' learning needs, clinical teachers plan activities based on the assessment. Learning activities help students to meet the learning objectives. For example, if the learning objective is to demonstrate an intramuscular injection in a young adult patient, learning activities are planned to provide an opportunity to practice the skills on a simulated patient first, and then to demonstrate the skill on the young adult. The planning of the clinical learning activities takes into account the learners' needs (Oermann, 1998); it is also important to consider the type of placement and the availability of resources at the site of learning.

Dolan (2003) suggested five steps in faculty planning of a clinical day. The first step is to select a patient prior to the clinical day. McCoin and Jenkins (1988) identified five possible methods of assigning patients to students: (a) The faculty assigns the patients, and students visit the clinical facility and review the patients' records; (b) the faculty member gathers the information from the patient record and gives it to the students; (c) students pick their own patients and review the records; (d) staff assign patients to students; or (e) a combination of the above is used.

The second step that Dolan discussed is communicating with the staff about the nursing students' objectives. The third step is using preconference time to assess the students' preparation and understanding of the patients' needs and stimulating the students' thinking by asking questions that require critical thinking. The fourth step is planning the day in advance based on the patients' and students' learning needs, and the last step is providing ongoing feedback to the nursing students based on their performance and learning needs.

Evaluating Clinical Learning and Performance

Malek (1988) asked a sample of nursing students the question, "What has been the most anxiety-producing aspect in the clinical experience?" (p. 65). They identified clinical evaluation as one of the top four anxiety-producing situations. In fact, it was first on the list of stressors if a student had encountered any negative interaction with evaluating instructors. The students perceived significant inconsistencies in performance expectations between clinical teachers and field-site preceptors. There are variances in clinical faculty expectations of the clinical performance (Caldwell & Tenofsky, 1996; Girot, 1993; Krisman-Scott at al., 1998; Morgan & Irby, 1978; Oermann & Gaberson, 1998) that are related to clinical practice beliefs and styles.

Evaluation of clinical performance is the most challenging task performed by the clinical teacher. Duke (1996) conducted a phenomenological study that explored the lived experiences of four sessional clinical teachers. Four themes emerged from the data: oppressed group behavior, self-esteem, role conflict, and moral caring. Duke attributed the first two themes to the participants' lack of confidence in the role of clinical educator and the oppression of women in general. Because all of the participants came from an apprenticeship-dominated style of diploma nursing education, the assumptions in the literature on oppression and gender stereotypes of women applied to them. In Duke found that the participants attributed students' difficulties to clinical teachers' own personal inadequacies in their new role of teacher. Although the participants relied on their 'gut feelings' when a student performed poorly, their overall responses to problematic situations were in the students' favor.

The final two themes, role conflict and moral caring, were related to the participants' moral dilemma of deciding between the protection of the patient and the students' rights. Duke (1996) reported that the participants expressed anger, frustration, and disappointment with their students when patient care was compromised. Although the participants had the ability to readily identify students' problems, they experienced personal dilemmas between moral commitment to the student and ethical responsibility to the patients. Despite the clinical teachers' difficulties with evaluation, all of their students passed the clinical course. Duke asserted that the relationship that developed between the teachers and students constrained the participants' ability to objectively evaluate the students. Duke also considered the clinical teachers' valuing of and ability to readily acknowledge psychomotor efficiencies in the students. This study affirmed the stress that faculty experienced and the role of conflict, especially when patients' safety was an issue, and recommended more educational support for those individuals who choose to teach students clinical nursing.

Evaluations are of two types, formative and summative. Formative evaluation is ongoing feedback in which a clinical teacher monitors students' progress towards the clinical objectives. Grading is not the objective of formative evaluation. Summative evaluation is conducted at the end of the course and assesses the overall performance of learners (Oermann & Gaberson, 1998). Oermann and Gaberson suggested five factors to consider in a clinical evaluation method: (a) it should determine how well students are meeting the clinical objectives; (b) it should be congruent with the clinical objectives in measuring the achievement of the students; therefore, multiple approaches should be used to evaluate students; (c) it is important to have a clear understanding of the purpose of the evaluation; for example, if it is a formative evaluation, then the clinical teacher should focus on the students' progress, accomplishments, and areas for improvement; (d) the evaluation methods should reflect the type of clinical activities; if the student is demonstrating a skill, then the evaluation method should focus on the performance and demonstration of manual dexterity and asepsis, for example; and (e) the evaluation method should not be a burden for the students and clinical teachers. In selecting the type of evaluation method, it is important to consider the type and number of students. In addition, in summative evaluation, time should be allocated to complete the evaluation forms and determine the grade (Oermann & Gaberson, 1998).

Conducting objective evaluation is not easy in the clinical setting. Studies have shown that clinical nurse educators are reluctant to make decisions that might alter a student's chosen career path (Malek, 1988). Wong (1978) added that clinical teachers are often frustrated about making final judgments on the inadequacy of students. Hepworth (1989) expressed concern that it is difficult for any evaluator to be free of bias. Duke (1996) studied Australian clinical teachers who frequently were inexperienced but who were expected to evaluate students' success in meeting the clinical requirements of a nursing course. These nursing teachers demonstrated low self-esteem, which contributed to their inability to hold students responsible for poor clinical performance.

Brookfield (1987) emphasized the threat of evaluation to the adult learner's ego and the responsibility of the evaluator to be sensitive to the adult's feelings. The author pointed out the tension in the relationship of trust between a teacher and a learner that influences the desire to achieve learning outcomes. According to Brookfield, an honest yet sensitive evaluation process should have the following 10 characteristics: (a) clear criteria and methods of evaluation in language that learners can understand, (b) immediate feedback, (c) regular feedback, (d) accessibility of the teacher, (e) individualized feedback that focuses on the learners' specific needs, (f) affirmation, (g) direction for future goals, (h) justifiable reasons for learning outcomes, (i) understanding of the purpose of the educational system within which the learning occurs, and (j) a focus on what the learners can achieve. Bondy (1984) viewed good evaluation as simple, fair, purposeful, related to the curriculum, and using multiple methods of assessing performance.

The literature identified various approaches to measuring competence in clinical practice. Two examples include norm referencing, as described by Krumme (1975), and the conventional ABC grading in which performance is judged against some kind of ideal model. Hellegas and Valentine (1986) developed a tool that is aimed at reducing problems such as subjectivity, short clinical-placement issues, and the assessment of different levels of competence. According to the literature and my personal experience in the clinical area, it is evident that clinical teachers are aware of the complexities of evaluation, and they use different approaches to assess the performance of students in the clinical area. Bondy (1984) suggested that using a criterion-referenced tool is the most effective way to a evaluate students' clinical performance. However, criterion-referenced tools have been criticized as being too behaviorist in nature (Higgins & Oscher, 1989; Krumme, 1975), especially if a checklist style of form is used for clinical evaluation. Regardless of the format, clinical evaluations are stressful for the student and the clinical teacher.

Different studies have been conducted to explore and foster an understanding of the implications of clinical evaluation for nursing students and clinical teachers. Three factors are vital in a clinical evaluation tool: objectivity, validity, and reliability (Krumme, 1975). Quinn (1995) defined *validity* as the relevance of a test to its objectives, which means that, to be valid, an assessment tool must test what it sets out to test. Because a clinical assessment tool measures competent clinical practice, it follows that a clear definition of competence is required to ensure validity of the tool. *Reliability*, according to Quinn, is the consistency with which a test measures what it is designed to measure. That is, the result of the assessment must be repeatable on different occasions, provided that the variable remains the same. It is important to note that in nursing the variables are not the same all the time because both the clinical teacher and the environment can change. Many tools are used for evaluation, such as rating scales, checklists, anecdotal notes, simulations, case studies, written assignments, journals, portfolios, clinical conferences, clinical examinations, and self-evaluations. Some of the common approaches are discussed below.

Rating Scale

A rating scale records the teacher's observations and judgments of students' clinical behaviors. The clinical teacher then rates the behavior on the scale. Scales can be letters (A, B, C) or descriptions (outstanding, very good, good, fair, or satisfactory/ unsatisfactory). Bondy's Criterion Matrix allows the clinical teacher to describe and rate a learner's performance on an outcome based on its appropriateness (Bondy, Jenkins, Seymour, Lancaster, & Ishee, 1997; Krichbaum, Rowan, Duckett, Ryden, & Savik, 1994). Rating scales are commonly used in the clinical area; they are effective if the clinical teacher has had an opportunity to observe performance over a period of time. Observing behavior and rating its quality is a subjective process, and the clinical teacher and nursing students may have different perceptions. Rating scales are also effective when they are combined with other methods that do not focus on observation.

Checklists

A checklist includes a list of steps of procedures. It includes behaviors that are to be observed. The clinical teacher checks the steps that have been completed or not completed. A checklist should include the critical components of the procedure rather than only the steps required to carry out the procedure (Oermann & Gaberson, 1998).

Anecdotal Records

An anecdotal record is a narrative description of the teacher's observations of students in clinical practice. This may include a description of the behaviors observed and the teacher's interpretation of the performance. Gronlund (1993) suggested keeping the interpretations separate from the behaviors observed. The information recorded should be meaningful and recorded as soon as possible after the observation is made. However, the documentation should have enough information to be understood when it is read later (Gronlund, 1993; Oermann & Gaberson, 1998). Observations of students that are recorded in anecdotal notes should be discussed with the students. Thus, anecdotal notes are valuable documents that indicate strengths and weakness based on the observations.

Written Assignments

There are many types of written assignments, such as nursing care plans (NCPs), concept maps, portfolios, case methods, and concept analyses.

Nursing care plans (NCPs). Care planning is an essential part of health care and has been used in nursing for a long time. In the process a student assesses a patient, writes the nursing diagnosis, specifies the short- and long-term goals for the interventions, plans the intervention, implements it, and evaluates the care provided. NCPs enable students to analyze a patient's health problems and plan care accordingly.

Care planning provides a "road map" of sorts to guide a patient/client's care. To be effective and comprehensive, the care-planning process must involve all disciplines that are involved in the care. The first step in care planning is assessment. Once the initial assessment is completed, a "problem" list is generated. The problem list may be the actual or potential problems that affect a patient's well-being. The goal, which should be specific, measurable, and attainable, is to resolve the problem or to demonstrate signs of improvement within the review period. Periodic scheduled reevaluation must take place, with changes being made as needed. The purpose of the care plan is to guide everyone involved in providing appropriate treatment to ensure the optimal outcome during the patient's stay in the hospital. A caregiver who is unfamiliar with the patient should be able to find all of the information in the care plan that he/she needs to care for this person. Student care plans must include rationale based on current literature and evidence. The ability to base actions on evidence from the literature is an important aspect of evaluating a care plan.

Concept map. Concept mapping is a technique to represent knowledge in a graphical structure. In other words, ideas are presented in a form of a visual map of connections. Knowledge graphs are networks of concepts, and networks consist of vertical links. Nodes represent concepts, and links represent the relations between concepts. Concepts and links are labeled. Links can be uni- or bi-directional. Concept mapping can be done for several purposes: to generate ideas, to design a complex structure, to communicate complex ideas, to aid learning by explicitly integrating new and old knowledge, to assess understanding, or to diagnose misunderstanding.

Portfolio. The definition of a portfolio varies, but there seems to be a general consensus that a portfolio is a purposeful collection of assorted student work that is collected over time and is usually presented in chronological order (McMullan et al., 2003). It represents a student's efforts, progress, and overall achievements in a course or program of study (Karlowicz, 2000), and it brings to life the student's or nurse's education and skills (Serembus, 2000). A well-developed portfolio can transcend career and lifestyle changes (Weinstein, 2002).

A key reason for interest among nursing educators in portfolio development is the belief that portfolios provide documentation of complex sets of skills, and hence curricular outcomes (Karlowicz, 2000). Portfolio development invites students and faculty to become allies in the educational process. For example, through their interaction with a faculty mentor, community nursing experts, and even classmates, students are supported and encouraged to assume greater personal responsibility for learning (Karlowicz, 2000). Karlowicz stated that "collaboration promotes self-reflection and creates learning opportunities for sharing to affirm the acquisition of knowledge, behaviors, or competencies" (p. 83).

The portfolio is not only a beneficial assessment tool for student learning, but can also be used to accomplish other tasks that can benefit the educator and the nursing curriculum. Portfolio evaluation allows educators to reexamine their teaching strategies and the relevance of specific activities or assignments to the overall objectives of an individual course as well as the school's curriculum (Karlowicz, 2000). The portfolio development process requires that students reflect on their personal strengths and weaknesses to understand how they learn or why they failed to learn. Reflection can be defined as an important activity in which individuals recapture their experience, think about it, mull over it, and evaluate it (O'Mara, Carpio, Mallette, Down, & Brown, 2000). Students are reluctant to engage in self-reflection; they may fear that sharing weaknesses and areas for improvements will lead to a low grade, but the development of a portfolio should not be a feared assignment.

Even though the portfolio has been described as an effective method to determine competence in practice, not much research has been done to support this statement. There is little evidence to support the belief that the portfolio stimulates self-awareness, personal growth, and independent learning (Mitchell, 1994). Reflective practice does not always improve the nurse-patient relationship (Ball, Daly, & Carnwell, 2000).

McMullan et al. (2003) proposed that portfolios not only bring theory and practice closer together, but also lead to improvements in practice and allow students to take control of their own learning needs. There is a lack of research-based evidence to support the claim that portfolio analysis as a method of judging overall program effectiveness is comparable to other assessment techniques (Karlowicz, 2000). There is also a lack of research-based evidence that demonstrates the validity and reliability of portfolio analysis and the time required to create the portfolio (Karlowicz, 2000).

There are no studies that indicate that a score assigned to a student portfolio is measuring what it is intended to measure: the acquisition of knowledge and skills necessary for the delivery of competent nursing care (Karlowicz, 2000). The difficulty for nursing evaluators is in correlating the portfolio scores with other measures of program effectiveness such as standardized examinations. Reported scores are not comparable to those typically used for portfolio evaluation. Portfolios are very independent and not amenable to standardization; therefore, their assessment is often subjective (Pitts, Coles, & Thomas, 1999; as cited in McMullan et al., 2003). Clear guidelines on the purpose of the portfolio, the content, and the structure must be determined for the portfolio to be effective (Crandall, 1998).

A criticism of portfolios is that they are more time consuming to implement for both students and faculty than are other assessment methods (Harris, Dolan, & Fairbairn, 2001; Oechsle, Volden, & Lambeth, 1990; Wisker, 1996; as cited in McMullan et al., 2003).

Jensen and Saylor (1994) found that insufficient time to complete a portfolio is the greatest barrier to the completion of well-developed projects. Many students find the notion of developing a portfolio daunting at first (Serembus, 2000). Faculty must devote extra time to planning and preparing portfolio assignments, along with mentoring students through the process of portfolio development (Karlowicz, 2000). I found no literature that discussed at what point in nursing education a learner should begin to compile a portfolio. It would be interesting to compare a first-year student's portfolio with that of a fourth-year student and note the ability to reflect on competence in practice through each year of the program.

Case studies. A case study is a hypothetical or real-life situation in which students are expected to respond verbally or in written form. It includes comprehensive information about patent situations. Case studies provide background data about the patient, the family history, and other information for a more complete picture. Thus, students need to analyze case studies in greater depth because of the data provided in the scenario. One of the purposes of this method is to promote the development of thinking skills among students from a modeling of the thought process by the teacher to thinking by the students themselves.

Clinical Examination

Clinical examinations include Objective Structured Clinical Evaluations (OSCE), in which there is control over the environment and limited distractions (Oermann & Gaberson, 1998). These examinations are designed to evaluate clinical performance and are used to test a certain skill or set of skills (Marshall & Harris, 2000). If they are administered in a laboratory, each station is designed to reflect a given situation and assess one skill. Testing occurs in a simulated environment with "pretend" patients representing actual clinical conditions (Segura, Pola, Carretero, & Gispert-Magarolas, 1999). The OSCE test is timed, and there are usually two examiners in the room to assess the student's competence in performing the skill (Geddes & Crowe, 1998). OSCE can also be conducted in the clinical area with actual patients.

Segura et al. (1999) found the OSCE to be one of the most complete clinical competence assessment methods currently available. It is a useful performance-based tool in testing individual skills in essential components of needed skills. Although the OSCE has been recognized in various studies as a credible test of clinical competence (Nayer, 1993; Segura et al., 1999; Sloan et al., 2001), there are conflicting views regarding both the reliability and the validity of the OSCE as an assessment tool. Shanley (2001) concluded that OSCEs are inadequate in predicting/assessing the clinical performance of nurses. There are various concerns that have been explored that test the reliability of the OSCE.

There is also the potential for examiners to become fatigued during the day because they often assess a number of students in one test day and may inadvertently discriminate between individuals who are safe and competent to practice and those who are not (Nicol & Freeth, 1998; Shanley, 2001). Students may perceive the OSCE situation as incredibly stressful and may not demonstrate their knowledge and skills to their full potential.

I found no literature that considered the effectiveness of the OSCE in assessing student learning; however, it is used to evaluate nursing students' performance worldwide (Chabeli, 2001; Koop & Borbasi, 1994; Ross et al., 1988; Wilkinson & Fontaine, 2002). Because there is a lack of research on the OSCE, its validity can be questioned. Have students actually been able to integrate the knowledge that they have learned for their OSCE skill, or did they just memorize the checklist? Will they be able to apply it in their nursing practice? No studies on the OSCE indicate that the pass/fail mark often assigned to the OSCE measures whether students have acquired knowledge and skills for the delivery of competent nursing care.

The literature review identified the following aspects that can be considered to summarize the concept of clinical evaluation: (a) There is no perfect clinical evaluation process (Morgan & Irby, 1978), (b) clinical practice cannot be evaluated by one method alone; he range of behaviors to be judged in the practice settings and differences among learners requires a variety of evaluation methods (Reilly & Oermann, 1992); (c) evaluation feedback and guidance should be ongoing, with no surprises at the final evaluations (Ganong & Ganong, 1984); and (d) evaluation is, by its nature, a process that is complex and difficult, subjective, and value based. Issues of uniformity, consistency, and fairness in the measurement of behavioral skills constitute the ongoing debate on clinical evaluation (Fullerton, Piper, & Hunter, 1993).

Clinical Grading

Clinical teaching and evaluation of learning are complicated by the requirement of a grading system. Grading nursing students in clinical practice is one of the most challenging aspects of clinical teaching. Whitney and Boley (2003) stated that "faculty realizes students are sensitive about their grade point averages and that students must maintain certain grades for progression. Faculty also recognizes grading of clinical performance is complex and subjective by nature" (p. 198). Thus, it is vital that clinical teachers not fear failing a student for poor clinical performance, but they should be able to explain how they assigned grades and how they are related to the program and course objectives.

According to Haladyna (1999), teachers found grading to be the most difficult part of teaching. From the research on grading systems it is evident that educational systems have tried using numbers, percentages, letters, and pass/fail; but educators are still not always satisfied with the current grading systems (Y. Amarsi, personal communication, March, 23, 2000). Research in this area continues to be a challenge for nursing educators. Marcinek (1983) was unable to find a study that reported a significant correlation between academic predictors and clinical practice grades or clinical competence. The quality of clinical performance cannot be predicted from academic records; however, a significant correlation was found between students' clinical performance grades and evaluations of their competence as judged by self and supervisors (Miller et al., 1988). Meyers (1986) reported a strong correlation between low clinical evaluations and students' not completing the nursing program.

Stress Associated With the Clinical Experience

Clinical practice is stressful; students face uncertainties in caring for the patient, fear making mistakes, and worry about assessment and evaluation. Even though clinical settings provide opportunities for student learning and competency development, they tend to be stressful for students. Learning in the clinical area carries a significant amount of uncertainty and anxiety. Students often report that they fear making a mistake that would harm the patient. In addition, interacting with the teacher, other health care providers, the patient, and family members contributes to the stress. Students in clinical courses in baccalaureate nursing programs indicated that written assignments during clinical experience constituted an added source of stress (Oermann, 1998).

On the issue of anxiety, Carlson, Kotze, and Van Rooyen (2003) reported that students experience uncertainty in the clinical area because of the lack of opportunities to develop competence and that uncertainty is related to three factors: (a) a clinical teacher who is unavailable or inaccessible because of time constrains, (b) the absence of equipment to perform nursing duties and meet the needs of patients, and (c) the conflict in expectations between nursing school personnel and clinical nursing personnel in the hospital. The environment and problems that occur in real practice cannot be controlled (Lewis, Gadd, & O'Connor, 1987; Roberts & Brown, 1990; Van Ort & Putt, 1985; Wong & Wong, 1987). Practicing new skills in front of a clinical instructor increases anxiety levels in students (Policinski & Davidhizar, 1985), and stress and anxiety can negatively influence learning.

Clinical settings are stressful for clinical teachers; many factors cause anxiety in clinical faculty, such as ensuring that students get clinical experience to meet the clinical objectives within the limited time. Oermann (1998) looked into the factors that cause clinical teachers' stress and found that they are related to the limited time for teaching, the acuity of patients, and the number of students for whom the clinical teacher is responsible. In Pakistan a nursing student spends almost 75% of the program in the clinical area practicing practical skills. Thus the amount of time spent on planning a clinical experience is critical for a clinical teacher (Dick, 1986; Goldenberg & Waddell, 1990).

Oermann (1998) examined work-related stress that clinical teachers experience and identified 23 potential stressors, five of which include (a) coping with job expectations associated with their clinical teaching roles, (b) feeling physically and emotional drained by the end of a clinical teaching day, (c) feeling pressure to maintain clinical competence, (d) feeling unable to satisfy the work-related demands of work-related constituencies (e.g. students, clinical agency, and patients), and (e) teaching inadequately prepared students. As well, clinical teachers fear that students will make harmful or even fatal mistakes in the care of clients (Knox & Morgan, 1985; Wong & Wong, 1987). Kleehammer, Hart, and Keck (1990) viewed clinical experiences as important elements of the educational preparation of nursing students.

Clinical Placement

Clinical placements play a vital role in enhancing nursing students' learning. The uniqueness of the clinical experience has been recognized by many (Karuhlje, 1986; McCabe, 1985; Reilly & Oermann, 1992; Ripley, 1986; Wong & Stepp-Gilbert, 1985). Reilly and Oermann (1985) considered clinical experience the "heart" of nursing education. In nursing curriculum more than 50% of the time is often spent in the clinical area to promote competence. Therefore, it is important to provide an environment that is conducive to learning.

A clinical placement is a facility where nursing students put theoretical knowledge into practice. It may be a hospital, an agency, or a community. Enrollments in schools of nursing are increasing in response to the need for more nurses to meet health care demands. For example, at Dalhousie University in Halifax, Nova Scotia, Canada, nursing admissions increased from 80% in 1990 to 130% in 2002 (Ellerton, 2003). The problem of clinical placements is aggravated by the increased numbers of students and the downsizing of acute-care facilities. To resolve the matter of placement at Dalhousie University, the nursing faculty introduced a clinical preceptorship approach to accommodate approximately 20% of the students enrolled in the introductory course of nursing of children. In addition, the changes in health care settings create more challenges for nurse educators to prepare clinically competent nurses in practice settings with increasingly complex technological advancement and specialized care.

It is important to select clinical placements based on certain criteria, such as the compatibility of the school and agency philosophy, the type of practice, the models used, the availability of opportunities to meet learning objectives, the geographical location, the availability of role models, and the physical resources (De Young, 1990; Stokes, 1998). Selecting appropriate clinical settings may be difficult because of the large number of nursing students in the program. However, the availability of a placement does not ensure the effectiveness of learning in the clinical area. Edwards, Smith, Courtney, Finlayson, and Chapman (2003) determined the relationship between the type of placement chosen for clinical practice and competence. A quasi-experimental design using a pre- and posttest was administered to final-year students from Queensland University of Technology who had to select placements in either rural or metropolitan locations. The study highlighted the importance of both types of clinical experiences in developing students' competence and satisfaction with the clinical experience.

Conclusion

Clinical teaching is a guided learning activity that occurs in the natural environment of a hospital, health-related agency, or community (McCabe, 1985). It is not a simple process compared to classroom teaching, but requires the ability of clinical teachers to provide learning opportunities for nursing students to perform skills or procedures within a safe environment while protecting the rights of patients and maintaining high standards of quality care. Thus, the clinical teacher must not only instruct and support, but also evaluate the ongoing performance of nursing students to provide objective feedback.

During the clinical education component of nursing education programs, the process of socialization into the professional role begins (Dunn et al., 1995). Thus, in the clinical area students relate theory to practice and apply technical and interpersonal skills learned in class. In addition, they make clinical judgments, become socialized into the profession, and begin to appreciate its value and ethics (Dunn et al., 1995).

This chapter describes the complexity of clinical teaching, which requires that clinical teachers perform many tasks at once. I have explored three major roles of clinical teachers: facilitating learning; performing assessment, and evaluating performance. It is apparent from this literature review that clinical teaching warrants further study and that an exploration of clinical teaching in Pakistan may add to the body of literature on this critical component of nursing education.

CHAPTER THREE:

RESEARCH METHOD

In this chapter I present the study design, setting, and sample that I used and the ethical considerations that were required for the study to receive approval from the ethics board at two institutions. Being a PhD student at the University of Alberta required that I obtain ethical approval to assure that I did not violate the research participants' rights and that I informed them of the requirements of the research study. Because I am also a faculty member at the AKUH, I also needed ethical approval from my institution.

Study Design

The research design that I selected for this study was qualitative descriptive, because there have been no studies conducted in Pakistan on the topic of clinical teaching. Indicating the importance of the qualitative approach, Field and Morse (1985) stated that "qualitative research combines the scientific and artistic natures of nursing to enhance the understanding of the human health experiences" (p. 43). I hope that the results of this study will lead to more research on the nursing education system in Pakistan. Qualitative research involves the systematic collection and analysis of subjective narrative materials by using procedures in which the researcher has minimum control (Morse & Richards, 2002). It is used to draw out in-depth information and thus provides insights into the subject matter. Denzin and Lincoln (1994) described qualitative research as "modes of systematic inquiry concerned with understanding human beings and the nature of their transactions with themselves and with their surroundings" (p. 13). Qualitative researchers tend to emphasize the dynamic, holistic, and individual aspects of the human experience and attempt to capture these aspects in their entirety within the context of those who are experiencing them (Polit & Beck, 2004). Achieving a holistic appreciation of a subject requires using a qualitative approach. These in-depth studies usually require a small, selective sample (Morse, 1995).

In qualitative research rigor is maintained by demonstrating trustworthiness and openness, adhering to the philosophical approach, being thorough in collecting data, and carefully considering all data (Burns & Grove, 1997). Hence, qualitative research is used to describe certain aspects of a phenomenon according to the views of the subjects of the study.

In descriptive research (nonexperimental studies) the purpose is to observe, describe, and document aspects of a situation as it occurs naturally. It serves to generate hypotheses that lead to theory development. Descriptive studies are generally useful methods of collecting information in a relatively short time period (Polit & Beck, 2004). Hence, researchers use the descriptive method when they want to capture natural occurrences in discourse while obtaining in-depth information. The number of participants in the study is therefore kept to a minimum to allow time for each participant to explore the deeper meanings of their discourse.

Setting

In qualitative studies, generalizability is not the guiding criterion. Thus, the questions that guided the sample for this study are, Who would be an information-rich data source for my study? To whom should I talk first or what should I observe to maximize my understanding of the phenomenon? (Polit, Beck, & Hungler, 2001). To maximize my understanding of clinical teaching in Pakistan, I selected three hospitals in Karachi City in the province of Sindh for data collection, one private and two public; two government schools of nursing attached to hospitals; and one private school of nursing affiliated with a hospital. There are 77 government nursing schools in the country compared to 18 private institutions. However, even though there are few private institutions, these institutions have a major impact on nursing curriculum and the nursing profession at large.

I based my selection of the schools of nursing on the following criteria: (a) the institution's willingness to participate by signing the consent form, (b) whether the nursing school is attached to a teaching hospital, and (c) whether the nursing school produces more than 50 graduates a year.

Sample

The aim of this study was to discover meaning and to uncover multiple realities of clinical teaching in Pakistan. A convenience sample of three institutions that met the above criteria was selected. The sampling plan should be evaluated in terms of its adequacy and appropriateness (Morse, 1991). *Adequacy* refers to the sufficiency and quality of the data that the sample has yielded. An adequate sample provides data without any "thin" spots (Polit et al., 2001). When the researcher has reached saturation with a sample, informational adequacy has been achieved, and the resulting description is rich and complete. In other words, saturation is the point at which the participants provide no new information. *Appropriateness* concerns the methods used to select a sample. An appropriate sample is one that results from identifying and using study participants who can best supply information according to the conceptual requirements of the study (Polit et al., 2001). Thus, to maximize my understanding of the phenomenon, I selected a total of 60 participants for the study: 30 clinical nurse teachers and 30 nursing students.

I selected a minimum of five nursing students from each year (I, II, and III), which included 15 nursing students from the government institutions and 15 from the private institution, and I interviewed five clinical teachers from the government sector in each year and five from the private sector in each of the three years (Year I, II, and III diploma program). I also selected 15 clinical teachers from the two government institutions to complete the sample. Most of the government schools of nursing had just two or three clinical teachers for the whole program (Year I, II, and III; see Table 1 for the distribution of the participants). Thus, I assumed that combining the two government institutions would result in a total of 15 clinical teachers who conduct clinicals in the three years. The sampling technique used in the study was "volunteer sampling," which involved choosing informants who came forward and identified themselves as willing to contribute knowledge to the study based on their experience. A summary of the sampling is presented in Appendix A.

Approval From the Institutions

Private Institution

To obtain approval from the private institution I booked an appointment with the Dean of Nursing where the data were be collected. The purpose of the meeting was to share the research objectives and my plans for collecting data for the study. The meeting lasted for 40 minutes. Following this meeting, I attended a meeting of three-year coordinators to share the objectives of the study and to stimulate their interest in it. The plan was to set a date and time for each of the program-year meetings.

I selected the participants as indicated in Chapter Three. It was interesting to have five faculty representatives from each program year. They were full time and had three major responsibilities: clinical teaching, classroom teaching, and administrative work (which included involvement in committees).

Government Institutions

The selection of the participants from the government organization was slightly different. I needed to contact the head of nursing for Sindh, the directorate of nursing, to gain her approval to conduct the research study. After making an appointment with her secretary, I met with her in her office. Usually getting approval from the government sectors takes time because of the bureaucratic structures of the department. However, this time, after I reported the objectives of my study, I was asked to wait while the approval letter was typed, and I received approval within two hours. In this case approval from the institution was not required. A letter to the head of the School of Nursing was drafted to inform her that I had been granted permission to collect data from the institution and that assistance would be offered. I was given a photocopy of the letter. The next day I met with the principal of the School of Nursing to discuss the number of nursing faculty, and I decided to include one more government institute because the number of participants was not sufficient for the data collection. I again approached the directorate, and this time she made one phone call to the principal and I was granted permission. I recruited 30 nursing faculty members from the government and private institutions for the interviews. The nursing faculty at the government institutions had full- and part-time positions, whereas the faculty at the private sector were employed full time. Their responsibilities included clinical teaching and classroom and administrative tasks.

Use of Field Notes

Field notes are the record of work done in the field. It consists of the descriptions of events and incidents. Field notes can be taken by hands or can be computer generated depending on the researcher's preference. Field notes are critical in qualitative research, one can refer back on notes and explore on the significant events. Field notes are useful tool in analyzing the data.

I maintained field notes and conducted analysis on an ongoing basis to validate the data. I used the margins of the notes for coding the analysis. The notes included comments and any significant observations that would contribute to the study outcomes. I kept the field notes in chronological order for reference and included information about the place of the interview, the surroundings, and my impressions after the interview.

Selection of Participants

Gaining access to each institution to select the participants was dependent on permission from the administrative medical officer. Medical officers in Pakistan are usually male physicians who have administrative power over the hospital and the school of nursing. After receiving approval from these administrators, I contacted the matrons of the school of nursing by paying them a social visit to make appointments for meetings. I described the objectives of the study and sought permission to attend meetings for each program year to initiate the research process.

Selection of the Faculty Members

I asked for permission from the year chairs to share the objectives of the study in the faculty year meetings. These meetings are conducted by the year faculty members; the chair does not attend them. There is no restriction on faculty participation, regardless of years of experience. Therefore, I gave all of the faculty members who were in the room for the meeting a piece of paper and asked them to return it to me with identification if they wanted to participate or with no identification if they did not want to participate in the study. I had placed a box in the room in a convenient location for this purpose. I left the room after describing the study objectives and purposes to allow the potential participants to make their decision with no pressure; they simply had to indicate their willingness to participate in the study by depositing their slips of paper in the box. I used the same procedure for Year II and Year III in all three hospitals to select five participants from each year. If there were more than five volunteers per year, I randomly selected names on slips of paper in a hat. In meetings with potential participants I had explained the possibility of not being selected.

Selection of the Nursing Students

Nursing students were selected by contacting the president of the Nursing Student Organization (NSO) of each school. Every month the NSO holds a meeting in which nursing students from each year are represented. The attendance at this meeting was close to 95% of the student population, which ensured that most of the nursing students were present to receive general information on the study. Students are usually given incentives to attend these meetings; thus attendance is normally high. A nursing student chairs the meeting, and no nursing faculty attend. I gave the nursing students the opportunity to decide voluntarily to participate by contacting the NSO, with no pressure from faculty members.

With the permission of the president, I presented a brief outline of the study objectives and placed boxes in the room to facilitate selecting the participants. I gave all of the students a piece of paper, and, to reduce peer pressure, asked those who wished to participate to write down their names and put the slips in the box; those who did not want to participate were to discard the piece of paper or put it in the box without their names on it. I provided all nursing students with my contact number in case they required further information. I used the same process to select students from all schools of nursing. One of the criteria for selecting Year I students was that they had to have some clinical experience. In some schools of nursing clinical does not start until the second semester. During the selection process 10 nursing students from Year I who had had clinical experiences were selected from the three institutions.

Ethical Considerations

In this study I followed the ethical guidelines indicated by the ethics committee of the University of Alberta and the AKUH and received informed consent from the individual participants and institutions. To maintain the confidentiality of the participants and institutions, I allocated special codes. I gave the participants the freedom to refuse to answer questions and to withdraw their consent at any time during the study without penalty. Because some of the participants were more comfortable speaking Urdu rather than English, I made consent forms and information letters available in both languages. I wrote the letter and consent form in English and then translated them into Urdu. The accuracy of these translations was verified by back translation from Urdu to English. An AKUH colleague who is also studying at the Faculty of Nursing at the University of Alberta did translation. I conducted the interviews in English and Urdu according to the participants' preference. Copies of the information letter and consent form are found in Appendix B. The interviews took place in private locations in a hospital or a university office that were convenient for the participants. I guaranteed the participants' anonymity and confidentiality.

Data Collection

Different data collection tools can be used in a qualitative study. I considered using a questionnaire but felt that the nursing students and teachers might have considered it a threat and not participated. Second, most of the participants were not oriented to this form of data collection and therefore might not have understood the purpose of the study; thus the true picture of the situation would not have been depicted.

I also considered conducting focus group interviews. However, some schools of nursing in Pakistan still operate in the traditional manner where the teacher is seen as a figure of importance with powers and the students must obey the instructions of the teacher at all times. Thus, based on my working experience in the government and the private sector in Pakistan, I considered individual interviews the most appropriate tool for collecting data on the topic of clinical teaching.

Interviewing allows greater depth of information to be collected. There are three types of interviews: structured, semistructured, and unstructured. Considering the nature of this study and the nature of the participants, I selected semistructured interviews to gain in-depth information on the topic.

Interviewing Process

Semistructured interviews are characterized by brief guidelines on the themes, which allows a wider margin of flexibility than a structured format would. I tape-recorded the interviews, a professional transcriptionist transcribed them, and I then analyzed them. This process involved revisiting the interviews and matching them with the transcription to check for congruency in the data. Once the transcription was finished, I asked the participants to make sure that the transcripts accurately represented what they had said. I then e-mailed the transcripts of my first interviews to my supervisors in Alberta, who assessed the extent to which I was conducting the interview process appropriately.

Clinical teachers and nursing students. Most of the interviews were conducted at AKUSON, which was a convenient location for the participants. However, I had offered them their choice of location, and some asked to be interviewed at their own institutions because of their commitments. In addition, I provided transportation for the participants on the day of the interview if it was difficult for them to reach the designated venue. Booking the venue ahead of time ensured privacy. Before I audio-recorded the interviews, I received the participants' permission. The time scheduled for each interview was between 45 and 60 minutes. I gave them a choice of signing a written consent or providing verbal consent (which I audio-recorded) to participate in the study. Eighteen nursing faculty members and 12 nursing students signed the consent form, but the other half of the participants were reluctant to sign the consent and thus provided verbal consent. I then gave a copy of the information letter and the consent form to each participant in either English or Urdu according to their preference.

I began the interviews with a brief introduction of the research and a description of the purpose of the study, and participants introduced themselves. To collect data, I used semistructured interviews with probing questions when needed to elicit their understanding of the topic (see Appendix F for the semistructured interview questionnaires). I informed the participants prior to the interview that they could speak in

Urdu if they anticipated having difficulty expressing their views in English. The purpose of the interview was to gather as much information as possible regardless of the language used.

A professional transcriptionist transcribed the interview tapes in English, and a professor in Urdu literature from Karachi University verified the transcripts to ensure accuracy of the content. It was challenging to translate some of the Urdu sentences into English and to use correct grammar without losing the meaning of the sentence. Once the interviews were transcribed, I verified the consistency of the transcriptions and their congruency with the audiotapes. This process was followed for all of the interviews. The participants then rechecked the transcribed interviews to ensure that their message had been documented correctly and information had not been distorted.

To confirmed with ethical guidelines, I have kept the consent forms, audiotapes, and research material in a locked cupboard at AKU; and I informed the transcriptionist about the principles of anonymity and confidentiality, and she agreed in writing to observe these principles. I also left the tapes that I used in this study in Pakistan because bringing them to Canada would have been difficult. The tapes, transcripts, and consent forms are in a secure location at the AKU. I brought copies of the transcripts with me to Canada, and one of my supervisors will keep them in a secure location for five years. In the event of secondary analysis, I will seek permission from the AKU Ethics Committee.

I identified the interviews with different codes for each year (I, II, III) for the students and the clinical nursing teachers. Once the study is completed and ready for dissemination, I will give the participants a summary sheet on request.

Assessment of Qualitative Data

To evaluate the quality of the data and the findings, I used four criteria that Lincoln and Guba (1985) identified to establish the trustworthiness of qualitative data: credibility, dependability, confirmability, and transferability. Establishing credibility of the study involves taking steps to improve and evaluate the data; it refers to confidence in the truth of the data. According to Lincoln and Guba, ensuring the credibility of an inquiry involves carrying out the investigation in a way that enhances believability and demonstrates credibility. One technique that they suggested to improve the credibility of the data is to prolong the engagement or allocated sufficient time for data-collection activities to gain an in-depth understanding of the group under study and to test for misinformation. Prolonged engagement is essential to build trust and rapport with the informants. Thus, to ensure the credibility of the study, I allotted four months for the data collection, which I accomplished by interviewing 60 participants from the province of Sindh. Knowing the cultural orientation of the country and the language helped me to develop a trusting relationship with the participants in a short period of time.

I incorporated the clinical teachers' and nursing students' perspectives into the analysis of the study to gain a holistic understanding of the phenomenon under study. In addition, the transcripts were checked at three stages: first the transcriber verified their accuracy, then I checked for congruency with the tapes, and, finally, the participants read them to make sure that their message had not been distorted in the transcription. Furthermore, at all stages of the data analysis I consulted with my co-supervisors from the University of Alberta and incorporated their input into the process. This procedure ensured that I integrated scientific principles to achieve confirmability of the study outcomes.

The dependability of the study relies on a number of factors: the sample size, the analysis approach, and the dissemination of the results. Even though I used a convenience sampling, I identified criteria for selection. The sample size was adequate for this qualitative research because I believe that I reached saturation when the last interviewees did not generate any new information, but rather confirmed the views of earlier participants. I conducted the analysis of the data on an ongoing basis, and I plan to disseminate the results of this study at nursing meetings in Pakistan and to publish a number of articles.

With regard to transferability, not all aspects of the findings are applicable to developed countries because of differences in clinical models and resources. Nursing education in Pakistan has characteristics that are unique to this country. However, some findings are similar to those of Western literature. This will be further addressed in the discussion chapter.

Data Analysis

Qualitative analysis does not proceed in a linear fashion. I collected data from different sources such as researcher notes, observations, and interviews. I used an editing analysis style in which I acted as an interpreter who read through the data in search of meaningful segments. Once I identified and reviewed the segments, I developed a categorization scheme and corresponding codes to sort and organize the data using the method that Polit and Beck (2004) described. I then searched for patterns and structures that connected the thematic categories. The participants in the interviews shared narrative material that became the data for the study. I kept field notes, which added to the richness of the data. I allotted 45-60 minutes for each interview, but the participants spent more time sharing their concerns (a common cultural practice). On average, I spent 40 minutes with each participant. Because I had 60 participants, I expected the amount of information that I collected to be enormous. Thus, qualitative researchers often read narrative data over and over in search of meaning and deeper understanding. Morse and Field (1995) explained that qualitative analysis is "a process of fitting data together, of making the invisible obvious, and of linking and attributing consequences to antecedents. It is a process of conjecture and verification, of correction and modification, of suggestion and defense" (p. 126).

Morse and Field (1995) suggested four stages of data analysis: comprehending, synthesizing, theorizing, and recontextualizing. Comprehending is the process in which the researcher strives to make sense of the data and learn "what is going on." When comprehension is achieved, the researcher is able to prepare a thorough description of the phenomenon under study. This process is completed when data saturation is reached. The next step, synthesizing, involves "sifting" the data and putting pieces together to make sense of what is typical with regard to the phenomenon and identify variations. At this stage some generalized statements can be made about the phenomenon. The third process is theorizing, which involves a systematic sorting of the data. The researcher develops alternative explanations of the phenomenon under study and then determines their 'fit' with the data. The last process is recontextualization, which involves the further development of the theory, such as its applicability to other settings or groups.

The first step in analyzing the qualitative data was organization, and the main organizational task was to develop a method to classify and index the material. I used this process to reduce the data to a smaller and more manageable form so that it could be retrieved and reviewed. Categories emerged as I read the data and were thus based on the actual data. Once I had developed a categorization scheme, I reviewed all of the data for content and coded them based on the identified categories. Field and Morse (1985) suggested that the purpose of data analysis is to code the data to be able to recognize and analyze the categories. The second step was to develop a data filing system for retrieving the data. My co-supervisors were involved in each step to provide guidance and discuss my interpretations of the findings.

Organization of the Data

The invention of the computer has eased the load of the researcher. Some qualitative researchers believe that using computers can make analyzing qualitative data quicker and easier without the researcher's losing touch with the data (Anderson, 1987; Miles & Huberman, 1994; Taft, 1993). Computers perform functions such as processing, storing, retrieving, cataloging, and sorting. Data can be sorted without losing the information that the participants provided. I entered the data using Microsoft Word software, but I preferred to sort the themes and categories manually.

Conclusion

In this chapter I have described the study design and the rationale for using the methods that I chose to answer the research questions. I have elaborated on the selection process of the participants and addressed issues related to ethics, and I have discussed the analysis of the data in depth to give the reader an understanding of how I achieved the objectives of the study.

CHAPTER FOUR:

FINDINGS FROM THE FACULTY MEMBERS

This chapter includes the analysis of the data with respect to the questions that I posed to the faculty members of the three institutions in the province of Sindh, Karachi. The sample included the faculty from one private and two government institutions. I asked the participants 16 questions on clinical teaching practices in Pakistan. The topics addressed in this chapter include the profile of the faculty members, clinical teaching, views on teaching and learning philosophy, models of clinical teaching, characteristics of clinical teachers, the comfort level of clinical teachers, clinical experience and content expertise, teaching and learning strategies, written assignment, pre- and postconference, evaluation, clinical placements, stressors, the influence of culture on nursing, the theory-practice gap, continuing education, and clinical teaching in Pakistan.

Profile of the Sample: Nursing Faculty

A total of 30 faculty members participated in this study, 15 from a private institution and 15 from government institutions. The demographic profile of the participants is presented in Table 1. The majority of the participants were between 25 and 40 years of age. None of the participants in the government institutions were younger than 31 years of age. Two males (13.3%) from the government institutions, A and B, participated in the study. Of interest, the private institution has no males employed in its nursing school. Of the faculty members from the private institution, 86% were Muslims, and among those, 73% were Ismaili; none of the participants from the government institutions were Ismaili.

Table 1

Demographic Data of the Nursing Faculty

	Private		Government		Total
Demographic	n = 15	%	n = 15	%	n = 30
Age					
25-30	2	13.3	0	0	2
31-40	11	73.3	10	66.6	21
> 40	2	13.3	5	33.3	7
Gender					
Male	0	0	2	13.3	2
Female	15	100	13	86.6	28
Religion					
Muslim					
Sunni	0	0	8	53.3	8
Shia	2	13.3	3	20	5
Ismaili	11	73.3	0	0	11
Christian	2	13.3	4	26.6	6

Table 2 shows the participants' education. All of those from the private institution had a bachelor's degree, whereas only one from the government institutions had a baccalaureate degree. In Pakistan the eligibility criteria for nursing faculty to teach in the government nursing school is a nursing diploma (three years) and a baccalaureate, but only a diploma in teaching and learning (DT). This one-year diploma is offered at Jinnah Post Medical Centre in the province of Sindh.

Table 2

Level of Education of Nursing Faculty

Level of education	Private (n = 15)	Government (n = 15)	Total (n = 30)
Diploma	15	15	30
Bachelor's	15	1	16
Master's	1	0	1
Specialty*	0	5	5
DT	1	15	16

*Specialty areas are operating theatre, child health nursing, and labor and delivery.

Thirty-three percent of the teaching faculty from the government institutions had specialty education: a one-year program after the general nursing training. It is an additional course taken after receiving a diploma in teaching. The curriculum of this program is questionable because most of the graduates, even after receiving this education, lack the required knowledge and skills for teaching. As seen in Table 3, all nursing faculty from the government institutions had at least two years of practical experience on the wards. In the private institution six faculty members had 6 to 12 months of ward experience before joining the school of nursing.

Table 3

Clinical Experience of Faculty Members Prior to Teaching

Clinical experience	Private (n = 15)	Government (n = 15)	Total (n = 30)
6-12 months	6	0	6
> 24 months	4	15	19

Table 4 illustrates the teaching experience of the nursing faculty in government and private institutions. In the government institutions most of the nursing faculty had between four and six years of teaching experience, whereas in the private institution most of the participants had teaching experience ranging from two to four years.

Table 4

Teaching Experience of Nursing Faculty

Years of experience	Number of faculty: Private institution	Number of faculty: Government institutions	Total number
> 1	1	0	1
2-4	10	1	11
4-6	1	10	11
7-10	1	2	3
> 10	2	2	4

To facilitate analysis and discussion, I used hypothetical names for the participants who freely shared their experiences in the interviews. For those less vocal, I use the word *participant*. The two government institutions are labeled institution A and institution B.

Clinical Teaching

Question 1: What is clinical teaching?

The first question was intended to explore the understanding of the participants about clinical teaching. At the government institutions the usual practice is that nursing students are sent for their practical experience on a ward, and it is the staff nurses who supervise the students. The position of clinical teacher does exist in the government sectors, but the role is not supervision. These teachers go to the clinical area once a week to receive feedback from the staff nurses students' performance. However, in most of the private institutions the clinical teacher is responsible for facilitating nursing students' learning in the clinical area. Thus, it was interesting to hear the participants comments. Five major themes emerged from the discussions with the study participants. They saw clinical teaching as a continuous process, as complex and requiring competence for the provision of holistic care, and as important to the quality of nursing in the country. Table 5 provides a summary of the data collected for this question.

Table 5

Themes That Emerged on Clinical Teaching

Themes	Government institutions: A & B (n = 15)	Private institution (n = 15)
Clinical teaching as a "process"	4	14
Complexity of clinical teaching	6	13
Competence in clinical teaching	1	11
Holistic nursing care	0	4
Significance of clinical teaching in Pakistan	13	4

The following section includes the participants' narratives in response to the question on the nature of clinical teaching.

Clinical Teaching as a Continuous Process

Eighteen participants considered clinical teaching as a "process." This included those from the government and from private institutions. Meena responded, "It is a process in which faculty ensures that the students are facilitated in ways that ensure safety and demonstrate sound nursing." Gull said that "it is a process which has no boundary between supervision or evaluation." The concept of evaluation is further explored in the next question on evaluation. Similarly, Zoya reported, "We help our learners to perform certain skills that are expected to be performed with patients and help them become competent enough to do it with patients." This definition captures the broad understanding of the role of the learner. Hamida stated, "It is a process including supervision and facilitation." Susan viewed clinical teaching as a facilitation process: "It is the process of helping students to learn skills and knowledge, to enable them to work as efficient and proficient nurses in the clinical area when they graduate from the school."

The interesting observation in the above comment is the role of nursing students after graduation. This reflects the educational philosophy of this private institution's nursing faculty. Eight participants, including Razia and Anisa, simply responded, for example, that "clinical teaching is the teaching at a patient area." They did not elaborate further on their responses.

Complexity of Clinical Teaching

A total of 19 participants from both types of institutions expressed their concerns about the complexity of clinical teaching. One of the factors that they mentioned was collaboration with other health care workers and the expectation placed on the clinical teacher. Zoya stated, "Clinical teaching is difficult because one does not only have to work in the clinical area in isolation, but one needs to work with different people to enhance students' learning." Gull explained, "One comes across family members who belong to various cultures and present with different expectations of health care members. It becomes demanding to convince patient and family members that nursing students are competent in providing the care." Salma shared her views on the necessary attitude of government staff nurses in providing learning experiences for nursing students: "We need their cooperation for teaching as they are aware of the routine of the ward. For example, they have the keys for the cupboard where students can borrow the equipment to do the procedures such as vital signs." According to Meena, "Clinical teaching is challenging, as there is always unexpected things to learn," and "It is my tenth year in clinical teaching, but I still feel there is so much to explore about learners, evaluation, and teaching and learning." Mohammed stated that "clinical teaching is difficult regardless of the gender. I have noticed the same problems faced by the clinical teacher whether she is male or female. I am referring to the public's views and approach towards nurses." Anisa, with a specialty in labor and delivery, said, "Teaching maternal child health in the clinical is also not easy in a population with a high illiteracy rate." Thirteen participants did not provide a description of the 'difficulty' but simply said, "Clinical teaching is hard."

Competence in Clinical Teaching

Eleven participants from the private institutions and one from the government institutions saw competence in clinical teaching as critical. Their comments are included in a later section. Susan stated:

> Competence is the mastery of knowledge and skills first and then to be able to implement that knowledge and skills for the betterment of the patient in the real world. If students are lacking critical skills, the qualified teacher is one who helps students acquire the skills, refine the skills, and increase their strength and abilities. This learning process is important in the nursing profession, and I think Pakistan is lacking in this process; that's why nurses lose respect in society. The time has come for nurses to prove themselves in the society by being competent in their profession.

Zohra explained, "It is providing the students with competency in skills and enhancing critical thinking skills." Nine participants from the private institution simply stated, for example, that “clinical teaching requires competence in skills and knowledge.” These comments are further elaborated in the question dealing with the characteristics of the clinical teacher. Razia, with 20 years of teaching experience in the government sector, said, “Teachers need to ask students questions to provoke thinking. I know my content, and that’s why I have been the class teacher for Year III for four years.”

Holistic Approach

Four of the participants emphasized holistic care, and Susan elaborated:

> I encourage my students to provide holistic care. I like my students to see the patient as a whole, the spiritual aspects, the physical aspects, the psychological aspects (which is ignored most of time), and the psychosocial aspects. I also emphasize with students the importance to take care of the family; the importance of family members in the well being of the patient can’t be ignored in this culture.

Zoya observed, “Meeting the needs of the patient as a whole, not just the basic needs, which includes physical and mental, is important.” Bina commented, “Meeting the needs of the patients based on Maslow’s hierarchy starting from the basic needs such as food, shelter, to the highest level—that is, self actualization—is critical.” Gull said, “Assisting the clients to function at the maximum capacity is the role of a nurse; for example, assisting a stroke patient in self-care for hygiene as much as possible.”

Significance of Clinical Teaching in Pakistan

Thirteen participants from the government institutions felt that clinical teaching should be developed in the country to enhance professionalism. The rest of the comments are included in the question that asked clinical teachers how they would like to see clinical teaching in Pakistan. Farah commented:

> The concept of clinical teaching in the country is not developed. In most nursing schools clinical supervision is not done by the classroom teacher. It is done by the

> ward staff, who have limited experience of facilitation skills. We need facilitators who are assigned to students to guide their clinical experience. Being a classroom teacher, our priority is to cover the curriculum provided by the Sindh Nurses Examination Board. There are no courses or continuing education for nurse educators on "how to facilitate students learning in the clinical area" or "how to deal with unsafe students." We all follow the traditional approach of teaching; this is how I was taught, and I follow the same.

After a pause Farah said, "Nobody has so far criticized me; I believe I am doing right."

Eleven participants simply said, for example, "We need separate clinical teachers." Hamida stressed that "to become a clinical teacher, one needs inborn qualities of a teacher. Anybody can become a classroom teacher with training; this is not the case for clinical." Mohammed stated, "At present I am a clinical teacher, but I never go to the clinical. I do classroom teaching." Three participants from the private institution talked about the importance of faculty practice, which is discussed in question 15 on continuing education.

Views on Teaching and Learning

Question 2: How would you define your educational philosophy?

I believed that this would be an easy question for the participants to answer. I assumed that, being teachers, we all have a philosophy on which our teaching is centered. However, some of the participants were not familiar with the term *philosophy*. Second, I faced difficulty in translating this term into Urdu, and I had to rephrase the question; instead of *educational philosophy*, I asked, "What are your views on education?" This worked better for the participants, and they openly responded to the question. Three themes emerged from the data: lifelong learning, environment, and facilitation. The participants responded in different ways, as presented in Table 6.

Learning as a Lifelong Process

Thirteen participants saw learning as a lifelong activity. For instance, Zoya believed that "education begins from birth. Every child starts learning from day one of life and continues to learn throughout life." Similarly, Bina stated, "Education is a continuous process which starts with learning words. In every event one learns something; however, it depends on the individual how to use that knowledge in the practical world." Farida commented, "My belief is to enhance the learning among students who are admitted in this institution." Najma said, "Education is knowledge. One reads books and gains information. I believe one can also learn from reading religious books." Gull responded, "One's philosophy remains constant, but there are some elements that are added as time passes. It is lifelong learning. We continue to learn from the students' feedback and peers." Salma stated:

Table 6

Themes That Emerged on Education

Themes	Government institutions: A & B (n = 15)	Private institution (n = 15)
Learning as a lifelong process	1	12
Environment	3	2
Facilitation	3	11

> Learning is developed day by day, through education and experience. Education cannot be completed at one point, even if I do my PhD I can't say that my education is complete. Education is a two way learning process, the more we take, the more we are able to give, the more we are able to give, the more we will take; we have to be open for learning.

Environment

The respondents shared the belief that learning is linked to the environment. One of the less vocal participants said:

> The environment plays an important role in learning. If positive reinforcement is given to students they feel safe and comfortable asking questions. They will learn more as compared to when they are in an environment which does not promote questioning.

According to Razia, "Environment is a major motivating factor for learning. The environment has to be stimulating or challenging." Hamida agreed:

> The learning environment is very critical for learning. In creating situations for students to learn nursing concepts, one needs to consider how to make the environment non-threatening and safe to implement the nursing care activities with patient. Day one of the orientation is critical for students. I spend two hours taking them around the ward, introducing with the staff members and showing them the policy manuals.

Farah remarked, "Students in Year II and III are quite familiar with the ward and its routine. By Year II and III they work independently in the ward. They assist doctors with rounds." When Farah mentioned that students are familiar with the ward routines, she did not mean clinical learning; she referred only to the ward routines. Farida provided an example: "If students know where the otoscope is kept in the unit, they can hand it over to doctors when needed during the rounds for patients' assessments." This concept is further elaborated in the question on clinical placement.

Facilitation

Three nursing faculty, two from institution A and one from institution B, considered their educational beliefs related to the process of facilitation. Eleven nursing faculty from the private institution saw facilitation as their role; their responses are further addressed in question 3. The responses here were from the government-institution participants. Najma suggested, "To teach nursing students." Anisa elaborated: "My responsibility is to make sure that students pass nursing exams. I guide them in the class how to learn the pathophysiology of the diseases. This is the major concern of most nursing students." Mohammed reported, "I encourage students to ask questions on the topic I teach. We have discussion on the important topics such as cirrhosis of liver, Hepatitis B."

In asking the above question, I explored learning as a lifelong experience, the impact of environment on education, and the process of facilitation in learning.

Models of Clinical Teaching

Question 3: What are your comments on models of clinical teaching?

In this section I explored the understanding of the participants of clinical models. The question reflects the process of clinical teaching. The term *model* seemed complex for some of the participants, and I had to rephrase the question: "How would you like clinical teaching to be conducted? Or how is clinical teaching being conducted?" It was difficult for the government institution participants to reflect on this question because of their limited exposure to the subject, because the teachers did not have to work at the hospital to update their skills, nor were they required to supervise nursing students. Thus, it is difficult to determine from the responses how clinical teaching is seen in Pakistan. Various models are used, depending on the type of institution and the resources available. The common approach is to assign students to wards based on their objectives, and staff nurses are responsible for facilitating their learning in the clinical area. Here it is important to point out the reality of the existing health care system, where during the morning shift two staff nurses are assigned to 50 patients, but in the evening, only one RN and student nurses. However, the staffing may vary in other hospitals.

In response to this question, 12 of the faculty members from the private institution talked about the trio model, and one mentioned a traditional approach. The teachers used the term *trio model* to mean that the clinical teacher, the student, and the staff or preceptor from the hospital work together to facilitate clinical teaching. The government participants saw it as a "haphazard approach." This section explores the different models of clinical teaching that the participants suggested (see Table 7).

Table 7

Clinical Teaching Models

Model	Government institutions: A & B (n = 15)	Private institution (n = 15)
Haphazard	9	
Trio model		12
Traditional		1

Trio Model

As stated earlier, in the trio model a student is assigned to a staff nurse in the hospital, and the clinical teacher, who performs the role of facilitator, works closely with the staff nurse to ensure that the student nurses have the opportunity to meet the clinical objectives assigned to them. This model is similar to the preceptorship model practiced in Canada.

Meena explained:

> Discussion about the clinical model has been a hot issue in our year meetings. We have been struggling to try new models every time in clinical to see which model is effective. I see the trio model to be effective which consists of three key members: faculty, preceptor, and student. This model to me is ideal in our situation. Preceptors are in ward areas all the time, they are aware about the current changes in the practice and faculty are not always current with new changes. Therefore, there may be certain areas in practice a faculty may feel incompetent as compared to the preceptor.

Zoya commented on the effectiveness of the trio model: "The effectiveness of the trio model depends on certain things which should be identified and put in place before implementation. The important factor is the relationship between the school and service." Susan responded, "The trio model is a good model, but it's important to see the level of students and the exposure and experiences of the third party; I mean staff nurses." Hamida commented on the level of the student:

> In the trio model it is important to consider the level of students. If we consider Year I students they should have interaction with faculty all the time but with senior students the trio model can work well. The reason being the senior students do not need guidance all the time. I think the trio model works well with Year II and III nursing students.

Salma raised an important concern about the trio model:

> It is critical to determine the readiness from our side and the hospital. If we want it to work out, then there are certain factors which we have to deal with first. One of the factors to consider is staff workload.

One of the respondents from the private institution who actively participated in this discussion stated, "One thing which is important to consider in the trio model is the qualification of the staff nurses. We need to ask ourselves whether we are looking into qualification, experience, or both when selecting the preceptor." Bina addressed the issue of the preceptor's increased workloads:

> One aspect to consider in the preceptorship model is if we are asking them [staff] to take this responsibility of being a preceptor then there should be some flexibility in their workload because that increases the workload. So, if they are facilitating our students the nursing faculty has to take some of their roles. Thus, there should be some flexibility in our workload as well. In order to implement the trio model we have to work on these things.

One of the participants commented on this clinical model:

> At the moment, we are working on the feasibility for implementing the trio model. It is not fully implemented yet. At the moment, due to shortage of teachers, we are exploring the possibility of the preceptorship model. We also hope this model would help in eliminating the communication gap which has been existed between service and education. This way the two departments shall come together, helping the students to learn in a healthy environment.

Gull said, "I think the preceptor model would be good if it could be implemented by providing incentives to the preceptors to motivate them." One of the participants shared her experiences during her elective in the BScN: "During my electives, my preceptor made a difference in my approach towards nursing. I was able to contact her all the time, was getting ongoing feedback, and I enjoyed one-to-one discussion." One participant mentioned incentives as a motivating factor: "I think the preceptor model is good if it can be implemented by providing incentives to the preceptors to motivate them." Zohra expressed her thoughts: "I think I like the teacher preceptor model; it is better than any other model. Maybe I don't have that much experience in another model." A couple of respondents favored the trio model: "The trio model would help students," and "I would prefer the trio model." One participant stated, "I do not know much about different models because actually I am very new to this system, but based on the literature, the trio models seems to fit our system of education."

New Approach

Susan offered a new approach to clinical teaching:

> We have thought that the faculty should be working in clinical to develop skills and strengthen collaboration between the school and service. In this case a faculty would work three days in hospital doing the patient care and the rest of the days facilitating students at the clinical. She would be paid by the school, so that she is responsible to report to the school rather than service. The teacher would be fixed at the particular ward, so that she can build a rapport with the health team members which includes surgeons, physicians, pharmacist and dieticians. This is another model which we are working on.

Meena stated:

> With the present system it is one faculty for twelve students. If I am talking about my clinical area I have twelve students at three places, intensive care unit, coronary care unit, and emergency room . The whole day I have to run to three different places. Sometimes I am not satisfied because I missed supervising a couple of students. I cannot give proper attention to each and every student. Realistically it is not possible, but then I am trying my best. If the preceptorship model would be in place then it would be helpful for students' learning.

However, Salma indicated the importance of faculty being acquainted with the ward: "It is important for a faculty to know the ins and outs of the wards."

Traditional Approach

Discussing the traditional approach, Farida observed:

> Right now the faculty who are teaching theory are taking students to the clinical area. Faculty expertise is very much necessary, especially in the critical care area. If I am not expert in operation theatre, then it is very difficult for me to assess if the students are meeting their learning objectives in OR.

Haphazard Approach

I chose to use the term *haphazard* to describe the government institutions' approach to nursing students' learning. One participant, on being asked about the clinical models, stated, "I have to think about it." Mohammed described the prevailing practices in most of the government nursing schools: "No teacher goes with students; they go by themselves. There is no monitoring of what students are doing in the wards. That's why our nurses have poor clinical skills." Another respondent mentioned the reality of the life of the students: "Students work the night shift, which is a twelve-hour shift, and in the morning they are expected to attend the classes. How is one going to retain the content taught to them after being tired?" Anisa stated:

> Year I, II and III nursing students are scheduled for three shifts: morning, evening, and night. They go on the ward without guidance and objectives. The only thing they know is the name and the type of ward. We have an acute shortage of staff nurses at our hospital; students help to cover the ward shortage.

One participant reported, "Students get a stipend of 700 rupees [CAD $17] per month." Another said, "I have no time to go to the ward daily. I go once a week and ask the staff nurses about students' performance." Maria had "no problem with the present system. Students go on the clinical, work with the assigned staff nurse. She helps the students to perform the skills on the patients. We had no problems between student and staff." Razia asked, "What is the problem in the present clinical practice?" Another said, "Staff nurses have being doing a good job for years, so why worry? By itself we tend to be busy all the time. By the year III a nursing student is able to manage the whole ward by herself." One participant simply said, "The present model for clinical teaching is good."

I asked this question to identify the dominant models of clinical teaching in private and government institutions in Pakistan. The participants from the private institution expressed their views on the trio model and its applicability for nursing education and identified a need to develop a new model for clinical teaching. The government participants did not have a particular framework for clinical teaching.

Characteristics of a Clinical Teacher

Question 4: What do you think should be the characteristics of a clinical teacher?

The participants identified a number of characteristics: knowledgeable, skilful, able to motivate, able to role model, ready to learn and teach, humanistic, and self-directed. Table 8 provides a summary of these findings.

Table 8

Themes That Emerged on the Characteristics of Clinical Teachers

Themes	Government institutions: A & B (n = 15)	Private institution (n = 15)
Knowledgeable and skilful	15	15
Able to motivate	-	6
Able to role model	2	13
Readiness to learn	-	1
Humanistic attributes	2	3
Self-directed	-	3

Knowledgeable and Skilful

All 30 nursing faculty mentioned knowledge and skills as key characteristics of nursing faculty. Gull stated:

> I believe the clinical teacher is a person, who must be knowledgeable. When I say knowledgeable what I mean is a clinical teacher does not have to know each and everything, but she should know the content she is teaching. Teachers need to know the content to help students in practicing skills.

Zoya said, "A clinical teacher needs to be skilful, knowing about the skills she is teaching in order to support students in their learning experience." Bina responded:

> When I take my group of students to a clinical area, I help them to integrate the theoretical content taught in class to implement it in the clinical area. Sometimes the practical skills are performed differently from what they are taught in the skills Lab. For example, a nursing student may perform a catheterization on the patient without using a perineal drape. At this moment it is important that the clinical teacher discusses with the students the alternative measures that could be taken in performing procedures while maintaining asepsis.

Ruqia expressed her opinion: "I have four years of teaching experience; based on my limited experience I would say that a teacher should have a thorough knowledge in each and every dimension." She gave the following example:

> She should know about what drugs are available; how these drugs are metabolized and how do they act for patient care. The other thing a clinical teacher needs is to be able to relate how science, physics and chemistry concepts apply to patient in the real setting.

Susan stated:

> If you talk about knowledge, you have to have knowledge and you can get more knowledge by reading and keeping abreast with what's happening globally. This can be done by reading in local newspapers and bringing relevant topics to class. You cannot just take nursing in a vacuum. You have to see what is happening in the country and in the nation. Knowledge building is important depending on what skills one is teaching.

Similarly, Mohammed asserted, "Faculty should have up-to-date information and knowledge of the nursing literature. A teacher should share learning experiences with students and facilitate students' learning. It is crucial to give timely feedback to the students." One of the less vocal participants from institution B commented that "faculty should be aware of new teaching/learning strategies as times are changing and those strategies need to be integrated in teaching." Meena believed that "if a clinical teacher is in ICU, she should know what recent technologies are used in patient care and be able to operate that machinery." Maria shared a comment on feedback: "Faculty should be objective and give constructive feedback, and this requires knowledge and skills." Zohra agreed:

> A clinical teacher should have good observation skills because nursing is a practical field. A clinical teacher should have hands on experience. It is not sufficient that one has good theoretical knowledge but one needs to do skills practically in front of students or patients. Then in my view that teacher is a good clinical teacher.

Hamida recommended, "You have to be in the clinical area to prove your skills and demonstrate credibility," and Najma commented, "A clinical teacher should have expertise on the topic she is teaching. If the clinical teacher is expert on the content, only then she can be a good clinical teacher." With regard to skills competency, Gull said:

> One more thing that I value very much is that until the faculty member has not performed skills by herself she would not be able to put all her learned concepts for students and be able to explain how she is able to do the procedures on the patients. She would not be able to share her life experience with the students, so I think faculty practice is critical.

Farida shared her views on experience: "I think experience is the best teacher. Some people are born talented, but experiences incorporate reality in teaching." Mohammed argued:

> Teachers are less competent in skills because they have poor knowledge. They don't have a good education background. They grow up in poor environment so these are the factors which lead them to become incompetent. Every nurse should be competent.

Furthermore, "A teacher should have enough knowledge about clinical practice and have around ten years of experience." On being asked why specifically 10 years, he stated, "I think by this time period an individual is experienced enough in the profession and therefore can guide students appropriately in the practical life."

Able to Motivate

Six of the nursing faculty highlighted the need to motivate nursing students, and Susan expressed her views:

> I built team spirit among students by encouraging them to ask questions. I believe that all of them have strength and I capitalize on that strength and work on it. My focus is to work together with the students in harmony.

Salma felt that "a clinical teacher should have internal motivation and trust in the students" and Meena that "a teacher should have motivation to facilitate, give effective and positive feedback, because student are like wax, and a teacher can mould them in the shape she wants to mould them in the profession."

Bina, who is enrolled in the master's program, shared her concerns about the myths that exist in educational culture:

> A teacher does not need to be always right because she is a teacher. A teacher can be friendly with the students while maintaining the professional boundaries. If I am a teacher that does not mean that I know everything. With the advancement of the new technology we should not underestimate the students. Sometimes when I go into my class they are more equipped with the recent knowledge then I am. They challenge me on the content, which is good. I encourage them to question me at all times in the classroom and in the clinical area. I observe students coming up with more questions for next class. It is important to motivate students to ask questions at all times.

Zohra explored the process of feedback:

> Why are we monitoring students while performing skills on the patient? I think it is important to provide ongoing, constructive feedback. No student is perfect, but it is the faculty member who needs to guide individual students to perform the skills at the desirable level.

Farida stated, "Once you give feedback to the students, it is important to guide their work. If you give them feedback and don't facilitate them on where to go, then it's useless to give such feedback."

Able to Role Model

Role modeling was highlighted a number of times during the interviews. Thirteen faculty members considered it important to the learning experience. Zoya stated:

> I do not know much about the characteristic of a clinical teacher because I am very new in to this system, so I might not be able to say what my student would expect of me, but since I have been a student myself a few years back I exactly know what I have seen in my faculty. I have my faculty as role model. There was the proverb saying, "practice before you preach," so they were the ones who actually practiced before they taught us. They were actually performing the skills and incorporated concepts in practice. This is a true role model because they would implement the skills themselves first.

On the same topic, Ruqia responded:

> If a clinical faculty has hands-on skills that would really make a difference while teaching students. If I think that I am not competent enough to do that skill, and I just have theoretical knowledge, and if I would expect my students to do that skill, then that is not really wise, so to be competent ourselves would be a very important factor.

Zoya added:

> I became a nurse because I wanted to be a nurse; for me nursing comes naturally. The teacher needs to be genuine in her approach with students and not artificial. Students can see through when you are acting or when you are genuine in your deed. I role model when I am in a clinical setting. I interact with the patients and relatives and the students see it. And, when they see it, it becomes part of them.

Razia explained, "Role modeling is another attribute which I feel is important, because students look at you as superior to them, so you have to prove yourself by demonstrating professionalism." Bina concurred:

> Whatever we expect from the students should be practiced by a faculty first. If I tell students to be on time, I should practice first; and if I tell them to follow the proper dress code, I also should be in the proper dress code. The role modeling is important.

Hamida saw role modeling as "the important feature in clinical teaching. In most situations the nursing students can't perform the skills as demonstrated at the school for a number of reasons. One of the reasons is lack of resources." Farida supported this idea: "Role modeling is a complex phenomena. A faculty needs to represent professional attitudes at all times." Susan expressed her views:

> We have to be a role model so that the students can learn by example. It is critical to let them do certain experiments which will promote their learning. As a clinical teacher it is important to encourage and provide positive encouragement. Asking them about their experiences and questioning what works and what are the factors causing a barrier to learning is important. This learning process can be facilitated by sitting together as a team and discussing different approaches. In this case a teacher is like the captain of the ship; she has to show the students how to integrate, how to make learning meaningful and only when she does it can learning takes place.

Readiness to Learn

Hamida was the only individual who mentioned this topic:

> A few things which I believe should be present in a clinical teacher to be effective are readiness to teach and readiness to learn. The other quality in a clinical teacher is the expertise of facilitation because I believe a teacher is a born teacher. It would be difficult for me to believe that any one can become a teacher because I believe that you have to be a born teacher.

Humanistic Attributes

Speaking about humanistic attributes, the participants had different perspectives, and Mohammed advised, "A clinical teacher should be polite, knowledgeable, motivated, ethical and a hard worker." Meena commented, "Students should not become threatened to ask questions and should be comfortable working with their teacher." Gull contended, "I talked about a knowledgeable, confident person. If you do not know anything, you just need to accept that 'I do not know.'" Salma suggested, "Nursing faculty should be approachable, especially when students need them." One of the less vocal participants from institution A commented:

> We have to keep those old traditions of sympathy, empathy and caring, alive in the nursing student. This is the core of nursing and if that essence is going away, then I do not know where nursing is going. We have to keep all those feelings alive.

Self-Directed

Three participants from the private institution focused on the self-directed learning approach. Susan believed:

> To keep up with the advancement in the nursing profession one needs to be self-directed. There are many ways and means for a teacher to select. She can go to the skills lab to watch videos, she can talk to other nurses of that area. She can also go to the unit and work with the patients and see what is happening in the nursing area. She can go to nursing educational services and find out what's happening. So where there is a will, there is a way to learn.

Farida said:

> In this fast-moving world, the patients are becoming more demanding, they are more educated and tend to ask questions related to their health and we should be equipped to answer the patient. It is their right to know and we should be well equipped to answer them and we have to teach our students to answer them.

Bina responded:

> Nurses are expected to make critical decision for the patient care. Clinical teachers can't teach all the content a nurse needs to know to care for a patient . I believe if the process of self education is cultivated then a nurse can survive in this world. It is like a common phrase stating that it is critical to teach a person to catch a fish and he will never sleep hungry. Today's nurse can serve with the challenges provided she has the ability to think.

In summary, I asked this question to determine the participants' perceptions of the required characteristics of nursing faculty. They identified seven attributes:

knowledgeable, skilful, able to motivate, able to role model, ready to learn and teach, humanistic, and self-directed.

Comfort Level

Question 5: What are your views about comfort level in the clinical area?

In the clinical area it is important for nursing faculty and students to be comfortable while working. The comfort level is determined by the way that students and faculty are welcomed in the service area. This section discusses what the participants (the nursing faculty) thought about the comfort level.

For government-sector participants, this question was irrelevant because they do not supervise the students in the clinical area; it is staff nurses who facilitate students' learning in this area. Keeping this in mind, I framed the question broadly. In most cases probing was required because most participants simple responded, "I am comfortable." I then had to ask, "What makes you feel that way? Can you give me an example?" Four participants were unable to do so.

The following responses are from the private-institution participants, who were concerned mainly with interpersonal relationships. Najma spoke of her clinical experience in the government sector:

> I have maintained interpersonal relationships with staff. I come down to their level. I talk to staff in their language. Like, when I went to hospital A, the staff felt quite threatened by our presence. But I said no, we are nurses and we are family, so tell me what problems do you have and how we can help you. And we can work together. Now they know that I am there not to critique them but to work with them.

Susan described the attempts of a clinical group in another facility to be accepted in the clinical area:

> We try to improve the recreational activity for the patients. For example, we got a TV for the common room for the patients to watch during spare time. We tried to improve their dressing tray; we ordered equipment. I made dressing wrappers, showed them the autoclaving. So things have changed; it is difficult but not impossible. The administrative has to be convinced before changes are implemented. I am still working on certain things. I keep on trying, even if there is little improvement.

Ruqia stated:

> I am planning to give some lectures to promote a better relationship with the staff nurses at the other hospital. Hopefully then they will accept me and begin to trust me. A trusting relationship has to be developed among the staff for a better working atmosphere.

Zoya reported:

> Patients wait for Thursday and they wait for us to come. When they see my students and their caring approach, they say: where are you from? They tell us how different we are. That makes me and my students feel good. I am glad that my students are able to give quality care to the patients. The nurses also wait for us; when we go in the clinical area their work load is reduced, because our student nurses help them in nursing care.

Farida said, "No, I do not feel like a stranger in the clinical area. I have good IPRs [interpersonal relationships] with the management, nurses, and everyone in the ward. The patients look forward to us coming." Gull gave an example:

> Let me tell you about one of the incidents which took place with me in the clinical area. The doctor ordered to remove the catheter of a patient. The staff nurse was trying to clamp the catheter and then wait for two hours to remove it. According to what I have read in the literature clamping is not done. You remove the catheter without clamping; this is what is suggested in the latest literature. When I told her she was little bit annoyed with me. The next day, I took literature from the internet and gave it to her. Then she understood why I was saying that. Staff nurses think they are always right because of their practical experience. There are times when one faces problems for being accepted.

Another participant wondered whether "this is a jealously of nurses working in the hospital." Hamida said,

> Initially when I started going to clinical ward A, with my twelve students a staff nurse of that ward would look at me and say, "Here she comes again with her team." I remained quiet as I was a role model for my students. Now, the staff members know that I do not say any thing; in fact, I am polite with her. I had no problems with her behavior, and after a while she changed, and now she is cooperative when we approach her.

Meena shared her experiences: "I had to face a lot of difficult times to prove myself in front of staff and doctors. I had to work with the staff nurses, doctors, and students." Salma reported, "I had to come half hour earlier for clinical in order to plan students' activities and to provide a list of students' assignments to the staff." A participant suggested:

> It takes time to build up the relationship with the staff. Once you have done that you have won a victory. Now the staff guides me to select the patients and tells me which skills are to be done so that the students can get the opportunity to perform them. Once in a while I am also treated with a cup of tea. Building any sort of relation takes time.

Working in a comfortable environment is critical for nursing students and faculty to facilitate learning. Comfort is determined by the way that the students and the faculty are welcomed on the ward. This section discussed the opinions of the nursing faculty on the comfort level in the clinical area. Seven participants reported feeling comfortable, and four participants described their struggles to be accepted.

Clinical Experience and Content Expertise

Question 6: How do you see the clinical experience and content expertise contributing to students' learning?

This question evoked interesting responses from the government participants, who are not required to supervise students in the clinical area; nor are they expected to practice on the ward. Thus most of them responded that they believed that clinical experience and content expertise contribute to students' learning, but in reference to staff nurses. All of the participants from the private institution saw the contribution as immense. Additional comments on the topic are included in question 4 (characteristics of the clinical teacher).

Knowledge and Experience

Susan felt that "experience does not come overnight. Regardless of how knowledgeable you are, experience gives you skills to function at all levels. This is important for a clinical teacher." Ruqia explained, "Experience is very much important. When you work in a clinical area every day it is important. Every day you learn something which is critical, and that needs to be integrated into students' learning." Furthermore, according to Zoya:

> For me experience is not the only indicator. It is important but not the only indicator. If a faculty has ten years of experience, but if student feels uncomfortable to discuss their problem with her, to me those ten years of experience are not worth it.

Another participant expressed her concern:

> The clinical experience for the teacher has to be very good. She has to know her content. Being a good clinical teacher means having the ability to teach students to integrate what they have learnt in the classroom to the clinical area.

Commenting further, Gull said, "Well, I did not just become an experienced faculty within a day. When I came here, I hardly had any teaching experience. I had practical experience working in the ward, which is very important for a nursing faculty." Another participant responded as follows:

> When I look back at myself I feel I have grown so much. When I was a novice teacher, I was different in my approach. Now it is completely different, with all the education and the experience, I am a completely different person. My students

> feel comfortable with me as a clinical teacher. I used to be very particular about dress code especially making sure students do not put on any makeup and wear a clean white uniform. In addition to this I would never listen to any excuse if a student is late for a clinical I would mark them absent.

Susan voiced her thoughts in this way: "Experience teaches you a lot. Now, I can identify which students in the clinical group are having problems in the clinical area. Initially, this was a challenge for me." Recalling her experience, one participant stated:

> Knowledge and experience gives me the confidence to work with the students. Before I used to spend ages writing clinical evaluation and rephrasing what to say and how to say it to students who need help. Now I exactly know what to say and how to say. In fact, when to say what.

Hamida shared her early experience:

> When I joined the SON I had to face a new system. I was working in a Pediatric ward as a staff nurse. When I joined the school I was not sure about how clinical teaching was done. In the ward I was doing practical things but when I joined the school I was told about my assignment. I did not know how to treat students so I was very strict and hard, because I thought this is the way the things should be done. But with time one learns how to facilitate learning in the clinical area.

A participant reported, "It was very difficult to supervise a large number of students in the clinical area. I was unable to do that for some time until I learned how to plan my day in the clinical." Another added, "If I compare myself, I have adapted different approaches. I know how I can treat students in the clinical area. Experience brings lots of changes; one masters the skills of facilitation."

One of the participants suggested, "We have to change the way we think and deal with our students. I suppose the time has come where we need to consider students as equal partners in learning." Bina highlighted the importance of prior practical experience:

> I worked in ward A for two years before joining the school. When I used to take students in ward A it helped me a lot because I was aware about the system. But

> now when I am going to another ward things are totally changed for me. I think working in the same area helps faculty to work effectively.

Stressing experience, one participant said, "Experience of course is important; nobody can deny the importance of experience." Mohammed added, "I think both knowledge and experience are necessary." Another participant from the private sector shared her experience:

> I have all my experience in medical surgical and in CCU. So in those areas I feel competent enough. I might not be comfortable enough to teach my students in ICU as I have had limited exposure in dealing with a patient on ventilator.

Susan shared her views on the importance of practical experience:

> I believe if a nursing faculty has joined nursing school after graduation without having any prior experience working in the ward it would be difficult for her to teach practical skills. I believe there is not a single day in the clinical area when you encounter the same problem. The problems will always be different and practical experience is helpful.

Zohra believed that "if you want to be a good teacher you have to work hard. In order to know your content, you have to read." Elaborating on the qualities of a teacher, Hamida said:

> I believe faculty have inborn qualities and if you feel that you have those qualities it doesn't matter if you are a novice teacher. If one is able to deal with a student's problem properly than that faculty is more effective than the faculty who has years of years of experience and is unable to help the student.

This question dealt with the participants' opinions on whether clinical experience and content expertise contribute to students' learning, and they expressed interesting perspectives on knowledge and experience.

Teaching and Learning Strategies

Question 7: What are the teaching and learning strategies that you use in the clinical area?

In this section I discuss the teaching and learning strategies that clinical teachers use in the clinical area. The participants from the private institution emphasized the importance of the teaching process. Others themes that emerged from this question are highlighted in Table 9. However, it was clear from the interviews that the teaching and learning strategies depend upon a number of factors such as the ratio of students to teachers, the learning objectives, resources, and the expertise of the nursing faculty.

Table 9

Themes That Emerged on Teaching and Learning Strategies

Themes	Government institutions: A & B (n = 15)	Private institution (n = 15)
Innovation	-	4
Peers: Buddying	-	6
Discussion	8	11
Demonstration	15	15
Pre- and post-conference	2	12
Doctors' rounds	-	1
Nursing process	2	15

Innovation

Four participants from the private institution referred to the concept of innovation in teaching and learning. Ruqia described it as follows:

> Innovation is trying out new strategies for teaching and learning. Either you have a new idea or you have read from the literature about something which has been tried out in the west and now you want to try and apply it to our context.

Susan gave an example of an innovative strategy:

> I introduced concept mapping. In the beginning there was so much resistance from faculty but I kept on emphasizing its importance in developing critical thinking. I started it in my clinical, and then slowly, slowly I got other teachers involved. Now concept mapping has become a culture in the school. Every second person is using a concept map, but if had I given up then, it would not have been successful.

Zohra commented:

> Innovation is very important in clinical teaching. If I am performing a new strategy for the first time I will inform the students and tell them to give me some feedback. A couple of years back we had lots of students who were slow learners and there were issues in performing patient care. I was searching how to get them out of this and just came across a journal article which answered my concerns. I told students to form two groups. I told them to make nursing care plans and then go to the patient and carry out the plan. I did this for a week and discussed how it went. The student wanted to continue for the following week. I told them to write reflections and it was interesting to see how they helped each other. At the end it was interesting to see that all of the nursing students had passed the clinical rotation, even the slow students. The feedback was stressful and time consuming, but proved to be effective overall. Students learned how to help their colleagues.

Bina described different strategies used in the clinical area" "I have introduced portfolios to assess students' learning in the clinical area, which includes reflective practice summaries." Susan added, "With the present clinical group, I have used poems." Furthermore,

> on the first day of clinical I also use guided imagery with students which helps them to work with patients. I also had a poster display [called *gallery walks* in Pakistan] in one of the postconferences and invited other clinical groups to see them. So, they could see how much my students have learned and what creative ideas they can present in dealing with patients with various disorder. These are some of the things I have tried.

Meena reported, "I use case presentations to cover topics like spirituality, how to deal with the patients on ventilation, how to communicate with them. These are some of the topics we cover in the conferences."

Peers

This question was broad in nature and resulted in a variety of responses. One of the strategies mentioned was learning in groups. Susan's view was that "it is helpful to learn in groups." Gull stated, "If two students perform the skills and the rest of the group members are observing, students' learning is maximized by discussing with the group members." Ruqia remarked, "Sharing experiences among students, positive or negative, are memorable events in a student's life."

Four of the participants identified the 'buddying' system as a learning strategy. According to Susan:

> Buddying works well with certain students. Before, I used to buddy a slow learner with a fast learner. But now I sit with the slow learner, ask them to make simple objectives and work with them. They are no longer buddied with the fast learner. The reason is that the fast learners have given feedback that they get bored and frustrated with slow learners.

Meena commented, "I use peer teaching and ask them to question their group members about the nursing care and rationale," and Gull explained:

> I ask students to share with their classmates their experiences about how they dealt with patients. I have had no problems with students expressing their views in front of the other students. However the ethical principles are respected all the time.

Ruqia shared her understanding of slow learners:

> Unfortunately, I cannot define the slow learners although I read an article yesterday about how to identify the slow learners. I look into the characteristics such as not coming prepared with the clinical objectives, not being comfortable in providing nursing care to the client, having difficulty to report to staff or faculty on the condition of the patient and having difficulty to implement the interventions. With these indicators in mind I pick the students who are weak or bright; I do not label the students but I can identify who are slow learners. It takes at least a week to identify the students, who don't perform well in their first week. I talk to the students and give them opportunity to perform and if they are not

> performing well, I put them on a learning contract. I then follow up with the students on a weekly basis and give them continuous feedback.

Susan shared her view on slow learners:

> The slow learner is one who cannot share learning goals. This may be because of their culture or language, or the admission criteria for nursing which is equivalent of Grade 10 with an average of C. In most cases I have seen the students know every thing but they are shy or may be oppressed by the fast learner or they are not given a chance to speak and demonstrate their capabilities. I believe the clinical teacher should enhance student learning in the clinical area using varies approaches.

Discussion

Discussion is another important strategy for learning that 11 private-institution and eight government-institution participants identified. Fourteen participants simply stated, for example, " I use discussion." Salma elaborated on her response:

> It is not necessary to expect the students to perform all the skills on the patients, we can ask them to do it on one another, for example demonstrating a shampoo. They can practice with their peers and we can discuss how the skill can be modified in the case when a patient has a spinal injury.

Susan maintained that "discussion is a powerful teaching and learning strategy. It provides opportunity for critical thinking among students." Gull suggested that "students know exactly what to discuss in the pre- and postconferences. Students have become smart. I suppose we need smart nurses." Maria saw discussion as "helpful to facilitate learning," and Mohammed commented, "I discuss the content I am going to teach with the students."

Demonstration

Demonstration was mentioned by all of the interviewees as one of the major teaching and learning strategies to enhance practical skills. Ruqia explained, "There are different strategies used with different levels of students. I have worked with different levels of students ranging from beginner to the senior students. For neophyte students I have to show them everything through demonstration." Farida stated, "In this institution a clinical teacher first teaches in the classroom and then demonstrates the procedure in the skills lab."

In regard to safety, Salma said, "Once the students are aware of basic principles, then we take students to the wards, and then they perform the skill on the patient." Gull expressed her view: "First the teacher demonstrates, and then students are allowed to do the same skill on the patient. In this way students gain confidence in performing skills on the patients." Zoya's response was interesting:

> It is not necessary that we would expect the students to perform all of the skills on the patients; we can ask them to do it on one another. They could practice with their peers, and then we discuss how to perform on the patients.

Farah informed me that

> nursing teachers have been using demonstration as a teaching strategy for a long time. During the time of Florence Nightingale student nurses were shown procedures on the ward. Time has changed. Now nursing students practice skills in the demonstration room or skills lab before implementing on the patients.

Pre- and Postconferences

The participants had different opinions on pre- and postconferences. Some saw the preconference as more important, and others the postconference. It was difficult to determine whether conferences have a specified structure or objectives. Thirteen participants from the government institution did not respond to the question because they had limited knowledge of and experience with the subject matter.

Mohammed reported, "We do not have pre- and postconference. Nursing students are scheduled for the clinical experience in the ward where they work with the staff nurses." According to Zoya, "Pre- and postconferences are helpful for students. They can verbalize their fear and concerns about working in the ward." Gull observed, "Preconference gives directions to the students to plan their clinical day." Susan commented that "postconferences are to tie up all the experiences together." Farida contended, "Pre- and postconferences are very important, and the students feel the same way." Meena indicated the purposes of conferences: "In the conferences I cover clinical concepts, which I cannot cover in the theory classes because it is very much clinical-based content." Additional comments on the topic are provided in the question dealing with the pre- and postconference.

Doctors' Rounds

The participants considered doctors' rounds an important learning experience for students in the critical care area. Meena stated, "I ask students to accompany doctors on their rounds. I have small groups of students working in ICU and CCU."

Nursing Process

Bina discussed the nursing process:

> There are different teaching and learning strategies used to enhance clinical teaching; it depends upon objectives. If I talk about nursing process, I do it differently by asking my students to assess a client's need and then write a nursing care plan. I guide them with data gaps.

Meena suggested a method of enhancing students' learning: "I find it helpful to discuss nursing care plans with the help of Carpenito. I go through the nursing diagnosis and relate major characteristics of the diagnosis." Zohra added, "I like to ask students about what intervention they have done with the patient based on the identified nursing problem. In addition, what strategy are they using to evaluate care?" Zoya's comment was that "if students perform the interventions on the patients and then write the nursing care plan, students learn better. This helps them to rationalize their care better." Hamida, appreciating the importance of time, stated, "I like to discuss nursing care plans routinely, maybe once a week or twice a week depending upon how many contacts I have with the students." The nursing process is discussed in detail in question 8.

In the above section I discussed the teaching and learning strategies used in the clinical area to enhance nursing students' learning. Four participants from the private institution considered innovation in teaching practical skills critical to nursing curriculum. The other teaching and learning strategies that the participants mentioned were buddying, discussion, demonstration, pre- and postconferences, doctors' rounds, and the nursing process.

Written Assignments

Question 8 : What are your views about written assignments in the clinical area?

In this section the views of the participants on including written assignments in clinical teaching are described (Table 10). Written assignments include NCPs, reflective journals, portfolio and case studies, or any written material related to patient care. It was interesting to analyze this question because the concept of the written assignment was hardly mentioned by the participants from the government institutions. However, two did share their views, as did the participants from the private institution. Some participants considered written assignments useful to faculty in evaluating students' performance, whereas others considered them a waste of time, and the remainder had mixed feelings.

Ruqia did not see written assignments contributing to students' learning and argued that, indeed, they require a great deal of time:

> I am against written assignments. I think no written assignment should be given to the students. They spend half of the time trying to complete their written assignments. They have to fill in an assessment form which is three to four pages long; . . . three to four written assignments every week. I think they are spending more time in filling forms rather than on patient care. I tried this strategy last week only. I told them I don't want any written assignment for their patient. I instructed them to just work with the patient, . . . and it is their responsibility to read about the patients' pathology and medication. . . . And I told them that I shall ask them anything about the patient and they are expected to know. . . . It worked very well. The student said that after the clinical instead of making the nursing care plan and documenting in portfolios they spent time on reading pathophysiology and medications given to the patients. So I am totally against nursing care plan, portfolios and case studies.

Table 10

Written Assignments

Views on written assignments	Number
In favor	8
Not in favor	4
Mixed feelings	5

Meena, from the private institution, highlighted the importance of practical skills:

> I usually ask my students to do clinical work, which is practicing skills on the ward. They should not be doing any written work. I believe if they want to really learn something it is in the ward, where they get the opportunity for nursing skills.

Hamida, from the same organization, commented:

> I discourage students to do writing at the patient bedside. If nurses are standing in the patient area writing nursing care plans instead of working for patients, the patient families do not like this attitude of nurses. They believe nurses are there to

> provide care, not for written work. Written work is not considered to be benefiting patients. I like students to perform skills that would enhance their skills rather than writing long care plans which are copied straight from the book.

Zoya shared her views on teaching Year I students:

> Since I am teaching Year I, my students are very new to the health care system. They go to the patient unit but are not performing any skills. They spend the whole day talking with the patient rather than performing assessments. I have observed that they come and say that they are unable to find any nursing problem in the patient. But once when it comes to write nursing care plan they would have one prepared. I have not been able to figure that out. Year I nursing students' favorite nursing diagnosis are alteration in bowel elimination—constipation—alteration in body temperature—hyperthermia—and insomnia. I have noted that a patient may not even complain of constipation but the nursing care plan is made on it. It is interesting to teach Year I students.

One participant from the private sector raised a question: "Written work obviously takes a lot of time for the faculty members and students both, but again, the point is that if we do not do it, then what should we do?" Susan added to this argument:

> The question comes again, "Are we making our students capable of working in other environments?" Nowadays the world has become a global village. Nurses, who are trained in Pakistan, are going to foreign countries. They can go to any place but are they prepared to deal with the global nursing issues?. Have we prepared them for the challenges? I believe a clinical teacher can select the topic for the assignment based on her awareness of the global world.

Gull suggested reducing the number of written assignments in the clinical area to allow students time to practice skills: "I feel the extent of the assignment which we are asking from the students needs to be reduced."

Bina shared her experience:

> When I have 13 or 14 students at the clinical, I cannot discuss learning plans or nursing care plans on the first day of the clinical rotation. So I divide them in groups of three or four students each day, so that I can give them feedback. A times a students gets feedback on the fourth day and then there is hardly time left to evaluate the nursing care plan.

One of the participants from the private sector stressed the importance of written assignments:

> Nursing care plans, portfolios, and reflections are helpful. If students are taking one patient, I tell them to fill a three-page assessment form, but when they become staff nurses there is no time for detailed assessment. So when the students become staff nurses, these things are not applicable.

Susan lamented:

> The assessment form is a good tool to collect data from a patient, but when students go to the patients, it takes a lot of time because of the interruptions from the families. In this culture the families are to be answered all the time; they can't be ignored.

Salma explained:

> In the learning stage if we do not give written assignments we cannot assess the students because we cannot always witness their practice. We are not working with students all the time in the clinical. At present, the ratio is 1 clinical faculty for 11 or 12 students; it is very difficult to observe all the students at the bedside. There are certain things which I would like to see, how they have learned and I need evidence for that because we are grading them and marking them. . . . I personally feel uncomfortable to give pass or fail if I have limited evidence. I need to have evidence to evaluate their learning, and a portfolio is a good source of documentation. But if I rely only on written assignments that is a not a complete assessment of the student in the clinical area. They need to demonstrate the understanding of the content that is knowledge and be able to care for the patients.

Meena provided her views on NCPs:

> NCPs are helpful; the importance is how we relate the information written in nursing care plan to students in order for them to implement it with the patient. I ask a student to take a paper, draw lines and make a NCP at the bedside of the patient, apply the intervention and mark stars for left over interventions for the next day. It should be done this way rather than asking them to go to library, writing it from books and bringing the NCP the next day. Most of time this NCP is not even applicable, the problem may have been solved or the severity of the concern may have increased or decreased.

One participated stated, "As a faculty we need to learn how to modify assignments to make it applicable for the patients and to make it less of a burden for the students." Mohammed, from the government institution, shared his ideas on NCPs:

> When I got admitted to the nursing program in 1992, a new curriculum was introduced at that time. We had to learn to write NCPs. I was confused at that time but now I am considering that it is very useful for nurses and it should be a practice at all schools. It increases nurses' knowledge.

Another male participant from government sector stated, "I think it is a good process; students become aware of the needs of the patients. Based on the needs, the students can provide individualized care."

Concept Mapping

Susan considered the process of concept mapping in written assignments:

> Nowadays we use a clinical concept map. It is very good, but it should be looked at what level it is introduced in the nursing program. Are students ready to learn? Is it applicable in accordance to the culture?.

Farida explained:

> In third year we are expecting a student to complete a nursing care plan as well as the interview form; it is too much. The first step of the nursing care plan is to conduct the assessment and then the students fill out the interview form. Having the subjective and objective assessment, a priority list of diagnosis/nursing diagnosis is formulated and then a student justifies the selected nursing diagnosis with the faculty. After the priority nursing diagnoses is identified the student makes a nursing care plan about how they are going to help their patients within the given time period. Based on the patient's teaching need we are also expecting a student to prepare a teaching plan and a concept map. Concept mapping is for the disease process in which the students integrate pathophysiology, health assessment, and pharmacology to patient's condition.

Reflections

Zohra expressed her views on marking reflections: “I don’t give a mark to reflections because it’s their feelings; when the assignment is marked the originality of reflection changes. Besides that, the amount of time and energy a student puts into completing the assignment is tremendous.”

Another participant said:

> I ask my students to write reflections about their experiences for example what they did with their patients, and what was different about what they felt. How was this clinical experience different from the other one? In this case they can actually come up with their own feelings.

The focus of question 8 was on the types and applicability of clinical written assignment to students’ learning in the clinical area. The participants had a variety of opinions on the extent to which written assignments should be used in clinical learning.

Pre- and Postconferences

Question 9: What are your experiences of conducting pre- and postconference in the clinical area?

In response to this question, the participants shared their beliefs the contribution of pre- and postconferences to students’ learning in the clinical area. They were concerned about its effectiveness, the time duration, and the structure format. In government institutions the concept of pre- and postconferences is limited. Two respondents described the purposes of conferences:

- They provide an opportunity to share objectives.
- They provide direction to students.

- They allow discussion of cultural sensitive issues and the opportunity to role play.
- They help to develop interaction.
- They help to tie the learning experiences together.

Mohammed reported:

> The students go for their practical experience on the ward, and it is the staff nurse who monitors the performance of the students. We go once a week on rounds. We do not have pre- and postconferences for the students. When they come for the classes, we teach them the theoretical content.

Another participant from the government stated, "I do not conduct clinical conferences. I have no idea how much it contributes towards students learning." Gull shared her views on clinical conferences:

> In the preconferences I discuss students' objectives, asking them what they want to do on the clinical day. In this way this gives students direction to plan activities for that day. In the postconferences again it depends what an individual faculty wants to do with her group of students. What I usually do, is if a student has a different experience to share and I am aware the other students would benefit from sharing the experience, then we discuss it in a postconference. Apart from that if there is anything which students want to learn as a clinical group we share in the postconference. So, pre- and postconferences are helpful but it again depends how we utilize them to enhance students' learning.

One of the participants expressed her opinion on the importance of pre- and postconferences:

> I think we should have a preconference but not on a regular basis. I feel when we begin a new rotation with students we should have a preconference. The intent is to develop close interactions with the students. Students are not aware of faculty expectations. Beside that, the facility is new for the students so it's important to sit together and discuss the fears of the students. I myself don't have regular preconferences; it is when it is required. I think postconferences are very important; we discuss a patient's disease and care of the patient. In postconference we discuss many other things which we are unable to discuss at

> the clinical area. For example if a student has a patient who has an abortion, we discuss the legal issues and its impact on the patient.

Meena referred to the importance of role play and considering the cultural aspects of patient care: "We role play how to talk with the dying patient and how to care for patients considering the religious and cultural dimensions." In the same context, she elaborated, "There are things which we discuss in the conferences because of the limited time in the class. . . . We talk about staff issues, diseases, how to communicate with senior staff members and administrative issues."

Susan explained:

> Postconference provides an opportunity to talk about those things which are not discussed in the classes. I encourage my students to go to library and bring recent articles. I share the articles in postconference and sometimes we see a movie which is related to their patients. I believe conferences help to tie the nursing concepts to the patient care.

Farida related her views:

> The content for pre- and postconference depends upon the level of students and the nature of the courses. For example, if it is Year I students we are taking to the ward, there are certain things which a clinical faculty needs to discuss with students on a regular basis. There are certain skills they need to learn and discuss so we need time in postconferences. Theory class time cannot be utilized for these things so we need some time, at least 30 or 45 minutes. But when students are in Year II or Year III, I don't think that having a pre- and postconference every day is that important.

According to another participant, "We are working on a block system in which students go five days for the clinical, and on the last day we have a conference for an hour and a half or two hours to cover the whole week's objectives." Salma added:

> The pre- and postconference depends upon the nature of the course. If I talk about my course I have to give time to students for postconference, because we have to do reflections individually. There are so many things happening in the ward which students like to discuss such as any aggressive outbursts of the patients

> towards family or health care staff. Every day something is going on so we need time for the students to reflect on it.

Zoya questioned the effectiveness of conferences: "Postconference time has not been utilized properly; theory content is covered in postconference, and it shouldn't be happening."

In exploring the structure of pre- and postconferences, one of the participants stated, "Usually I don't plan for post-conferences." Another participant explained, "I don't think there's a structure for preconference. . . . It's discussing about the patient, type of patient, diagnosis, and interventions and exploring the learning objective for the day. Individuals have at least five minutes, . . . then they go in the wards."

The participants had various opinions on the time required pre- and postconferences: "The postconferences should not be more than fifteen to thirty minutes. If we do not have anything to discuss in the postconferences, we discuss in the wards." Bina argued:

> We go from 7:00 to 3:00 for the clinical practice. If we spent two hours in preconference or postconferences, it takes the time away from the patient. By the time the students go to their patients, . . . basic hygiene care is finished. So what are they doing at the patient's bedside? Standing the whole day communicating with the patient. Instead of spending a long time in conferences it is important students spend more time with patients in order to strengthen practical skills.

A participant summarized it in this way:

> The way pre- and postconferences are conducted varies from year to year, from faculty to faculty. When I say it varies from year to year, it is mainly because of the level objectives. For example, Year I nursing students, focus on the basic skills at the clinical area such as, bed bath and vital signs. In second Year, students integrate the knowledge and the skills learnt at the patient area, such as performance of the health assessment. We know each individual is different, so individual differences do exist.

With this question I was interested in understanding pre- and postconferences in the clinical area. The purposes that the participants described included providing the opportunity to discuss the clinical objectives with the clinical group, providing direction to students, and tying the learning experiences together. Three aspects that need further exploration are the effectiveness of the conferences, the structure, and the time frame.

Clinical Evaluation

Question 10: What strategies do you use to evaluate students' performance in the clinical area?

Evaluating students' performance in the clinical area has always been challenging for nursing faculty. The private-institution participants and one from the government institution expressed concerns about evaluation. In the government sector the staff nurses provide feedback to students, mainly verbally. Most of the responses to this question came from the private sector and are presented in Table 11.

Table 11

Themes That Emerged on Evaluation

Themes	Government institutions: A & B (n = 15)	Private institution (n = 15)
Evaluation: • HOW: Using a standard format (tool) • Influence: personality, subjectivity, nonjudgmental, experience • Process: continuous, complex, stressful, anxiety, critical and timely administration	1	15
Strategies: OSCE	-	4
Grading		10

Private Institution

Farida explained, "We have a standard form in which we have five major components, on which we assess student's performance in the clinical area." Another participant elaborated on the components: "We evaluate the students on five components: professional development, communication, nursing process, teaching learning and skills. I observe what my students do in the clinical and how they perform their skills. Based on that, I give them ongoing feedback." In Susan's institution:

> We have a standard format in the SON that we use for evaluating students. I believe in writing anecdotes; I write notes on things which the students have done well and those things which should be improved. For example any medication errors. I maintain the anecdotes daily and after two weeks I call the students in and discuss their performance in the clinical area.

Meena shared her experience of evaluation:

> I tell them about their strengths and weakness, so that they know on a daily basis where they stand. We have a progress report and final evaluation where students write for themselves and the faculty. I tell the students, if you are marking "P" [pass] make sure to give proper evidence. They need to provide evidence or examples and I make sure that I keep all the evidence with me and use it during the summative evaluation.

Salma saw evaluation and facilitation as "ongoing processes." One participant said, "We ask for a lot of written assignments, which helps us to evaluate their performances." On the limitations of the current evaluation form, another participant said:

> The evaluation form has different attributes. It is not a perfect tool; we are still working on it. We have developed different forms, but again there are so many things which need modification. Evaluating the students' performance in the clinical area is one of the complex processes for the clinical teacher.

A participant believed that "evaluation depends on how one judges the performance of students," and Zoya contended:

> I think one's personality might also affect it a lot. If I have a soft corner toward a student's performance I may not be neutral while evaluating her/his performance. Giving the clinical evaluation might some times hurt certain students who have performed marginally in clinical. Telling them that "you have not passed and you will be going into a learning contract" is not very easy for that student to accept. Most of the students start crying; at that time it gets difficult for me to separate from the students, when I see myself from the students perspective. I really get very sensitized to these issues.

One of the participants added an opinion on the complexity of evaluation:

> Evaluating students' performance in the clinical area is the most difficult task of the nursing faculty. One needs to assess a number of contributing factors which may affect the performance of the student in the clinical areas. It is important to make sure the student is not over stressed. Nowadays, nursing students are coming to nursing school with lots of family issues, which cannot be shared but these factors affect their performance in the clinical.

Gull commented, "Evaluations are always stressful." One participant questioned, "Why do evaluations have to be always stressful for the nursing student and the clinical teacher?" Farida reported her clinical experience:

> In some cases if a nursing student forgot to wash her hands would you fail her? Anxiety of being evaluated contributes to more mistakes. When a teacher is observing the students he/she feel nervous about their performance. The environment is a stressor for most of the students too. In this case one needs to be considerate of those factors. This requires experience!

Another participant gave an example of evaluation with regard to medications: "If I talk about medications, I cannot judge if I have to penalize or fail a student for making a mistake in medication administration. How can one judge on this critical component?" Another asked, "Can I fail a nursing student in third year? It is not easy for one to make that decision, especially in our culture when parents have high hopes for their daughter after graduation."

Zohra addressed the process of evaluation:

> When I give feedback, I ask the students about how have they learnt so they can tell me about their performance. After that, I look at my anecdotal notes, reevaluate them on the five components, professional development, communication, nursing process, teaching learning, and skills. I don't wait till the end; if I feel they are weak in any area of nursing, I say, look this is the area where you are weak in, lets work together. I refer them to different resources. I help them learn. If there is any deficit in the learning, I am not punitive. If you take a punitive approach students do not learn. One needs to know how to motivate students of this generation. I believe there are too many distractions for them affecting their performance: . . . Internet . . . [and] many more.

Susan suggested:

> It is important to be nonjudgmental. It is critical that the nursing faculty makes individual assessments about nursing students. If I had a negative feedback from another faculty about a student, there is a possibility that I will have preconceived thought about that student. I try not to do that. I look at students from different aspects at different occasions to come to a conclusion before the final evaluation. It is important to discuss with the students what is written in the evaluation so that they are able to identify their strengths and know their weakness and provide guidance to work for improvement.

Timely Evaluation

For one of the participants, providing timely feedback is critical:

> If the clinical is for four weeks, it is important that ongoing feedback is given to the students. Rather than waiting till the end of four weeks and saying "you are not competent in this clinical rotation." At this time the student does not have time to demonstrate improvement. But if a teacher provides feedback on the first week or second week then the student has time to improve.

Strategies for Evaluation

In discussing strategies for evaluation, Susan said:

> The diploma program is using a modified objective structured clinical evaluation (OSCE) to evaluate certain skills. For the last two years in the second year of the program, we have introduced a double jump and it is working out for us. We got in touch with McMaster University, in Canada, got material, and implemented it. We plan to continue to use this strategy.
>
> Another participant commented on this topic:
>
> The OSCE was a part of the evaluation but not included in clinical. At one point in time we said it is part of clinical because we are checking the performance. The students are not performing skills on the patients during OSCE, they perform on dummies. Performing the skills on the patient is different than performing on dummies.
>
> Gull's view was that
>
> The OSCE is not a part of the evaluation process. It was removed for some time, but now it is again used to check students' expertise on skills and that is also important because we cannot send students to the wards on their own without checking their safety in doing a particular thing. OSCE evaluates their performance, their expertise in doing things practically, and I think that's important.

Meena agreed:

> It is important to have a proper system of evaluation. One of the strategies is the OSCE in which a student goes through different stations to perform skills. In this process important areas of skills are covered. If the students passes the OSCE performance exam in the first attempt, that student is able to perform the skills on the patients.

Grading

Another important aspect of clinical teaching is grading. Zoya said, "We have grading scales like *satisfactory*, *nonsatisfactory*, and *fair*. Based on these scales we evaluate a student's performance in the clinical area." Another participant shared her views:

> We have gone back and forth, back and forth in the two systems, pass and fail and grading. Earlier in the school history we had a grading system. Having one

> teacher to eleven students, it was very difficult to tell a student you have 70%, 60% or a fail. If a nursing faculty had not adequately documented it is difficult for students and faculty to be satisfied. So, keeping those factors in mind, we went to the pass and fail system.

Susan also commented on grading:

> When it was graded, I felt the students were working harder. They were coming much better prepared and you could see more output. Since we have turned to the pass and fail, I see students very relaxed, and they say we will pass anyway so why work so hard. I see the difference in their performance.

Another participant contended:

> I feel that even in the pass fail, if there was a scale from 1 to 10 it would make a difference in evaluating students' performances. For example, if you pass, I say you pass at 5 on the scale of 10, where 10 is the highest performance. You can tell the extent of their output based on the scale.

One participant felt that "clinical performance should not be graded." Ruqia reported:

> There is lot of discussion whether it should be graded or nongraded. What I personally feel is whether its graded or not graded I know my students will work. I hardly have any student who is not working because its not graded. I never had a problem with a student who did not want to work because they knew that they will pass anyway. I know how I can motivate my students; I know how to make them work hard. I tell them it's very easy to fail but it's very difficult get a pass grade in clinical. So I think it all depends upon your own way of thinking. There are faculty who feel that if the clinical are nongraded, students will not work, but thank God I never had a problem with students not working because it is not graded.

Another clinical faculty with six years of experience remarked:

> I don't believe in giving clinical grades because we can create competition among the students and once the competition is there, surely it is not healthy competition. When it is graded they make the sure to make the faculty member happy and do things that are not required. I believe this is not learning. It is also seen in this case, that a strong student will not help other students because she wants to work for herself to get an A.

One of the faculty believed that

> It is very difficult to say that this student is 70.1 or 70.2; it's very difficult. I tell them they are passing but my written comments reflect how they have performed in the clinical area. I think clinical should be non graded so that students can perform well.

Hamida explored another characteristic of clinical evaluation:

> One cannot just pass the student based on the one performance. For example, if she is doing a sponge bath … to pass her I need to see different things, how she is doing the bath, is she able to communicate or is she just doing it like a robot, all these things are missed out in clinical evaluation. I am evaluating the safety of the procedure but to me talking to a patient is more important then just performing the skill (bed bath). Want I intend to see in nursing students is while performing the skills they should not forget to communicate with the patients. To me that is important and integral part of evaluation.

One participant said, "I would prefer the clinical grade as A, B, C and D. However, there should be some scale; otherwise just giving pass or fail or satisfactory or unsatisfactory in the clinical area is not worth it." Another participant advised:

> If there is a scale, then one can rate the performance. If students have performed at an unsatisfactory level, one needs to indicate the extent to which this occurred. For example in the scale of 5, where is the performance of the student in the scale of 0-5?. The student still needs a chance to improve and support is provided. The student should be given that room for improvement. However, what if in spite of additional support given to the students and still the performance is unsatisfactory...not a easy decision.

A participant volunteered, "This is a dilemma up until now, and we are debating it in each and every forum. In the past it used to be graded, and now it is pass and fail. We have not reached a conclusion."

Susan reflected on the qualities of the learner:

> Looking at the generation which is coming nowadays, they are very much marks oriented. If you give marks then they would work better and be more creative. I would suggest that clinical should be graded, no doubt the documentation and the objectivity, and the faculty workload would increase, but this is how I have learnt and have not forgotten up until now.

Evaluating students' performance in the clinical area has always been challenging for nursing faculty. The participants discussed strategies for evaluation, the process, and the outcome in the form of grading.

Clinical Placements

Question 11: What are your comments on the current placement sites for students' clinical experience?

Placement is considered a key element in facilitating clinical learning. The schools of nursing that I selected for the study are attached to teaching hospitals. However, in the private institution, because of the large number of nursing students and its objective of enhancing clinical experience, students are also placed in other agencies. The responses for question 11 are analyzed in two sections: The first includes the responses of the private-institution participants and the second, those from the government sector.

Private Institution

One of the factors to consider with regard to clinical placements is the learning objectives. One participant felt that "the present placement is meeting the objectives." Explaining the clinical experience, Ruqia said:

> Placement can be internal in the institution or external; that is, outside our school. Our hospital cannot accommodate so many students at one time for clinical experience. We have nursing and medical students; it is difficult to accommodate all students.

Hamida suggested, "The main thing in selecting a placement is the patient census and health care needs." Another said, "The placement is selected based on the clinical objectives and looking into the level of the students in the nursing program."

Farida indicated the impact of limited resources on student learning:

> Students have to be very creative to use resources while providing care to the patients, as there are limited resources. It enhances students' learning in a complex situation, but it is difficult for certain student to get adjusted in the environment, where resources are limited.

One participant described the criteria for selection of placements:

> In the initial phase when we look for the facility we take into account the safety. We look into security for the patients and staff. After coming back we discuss with the Director about the placement. We explore the areas we have looked into, the responses from the head of their department, the safety issues and administrative issues. Once it is agreed by the other party then the documents is signed describing the terms and conditions.

Susan stated, "The things to consider are the number of patients, diagnosis. Supposing if it is the cardiovascular or respiratory ward, we then see the resources available at the clinical site"; and Bina added, "In selecting the placement, the nursing faculty needs to consider what skills would be allowed to be performed by nursing students." One participant provided an example:

> Now at placement A we are not allowed to do anything for the patient. Even to give a bath to a patient we have to ask the consultant. Which I think is simple nursing care. Why do we need to ask the consultant? Even if we have to change the dressing we have to ask the consultant. So in the present placement I don't think students are benefiting anything from the experience.

Concerning the role of the clinical teacher, one participant reported:

> If the clinical teacher has not identified clinical placements based on the clinical objectives, the clinical coordinators are contracted. If the clinical teachers have to go to inspect the site, the clinical coordinator makes arrangement for the clinical teacher to visit the placement.

Zoya remarked:

> Sometimes we have to go out to search for new placements. This time we had gone to two to three places in between the semester. The facility was willing to

> accommodate our students, and they had all the equipment available. Being a clinical coordinator we also look for the students objectives. We make sure that the course coordinators, and year coordinators also come with us to confirm the placement.

In regard to providing a variety of clinical learning experience, a participant explained that

> If all the three years were going to ward XYZ at the same time, that would be too much. There would be one patient and four to five student nurses to give care. Thus, we have to look for different placement in different hospitals.

However, Susan cautioned, "Administrative issues are to be considered before going into the details of the placement. One thing is looking at the readiness of the other institution." One respondent commented, "There are certain clinical areas where students are not safe, so we have to look for another placement." One of the participants shared her views on limited clinical placements for mental health:

> We don't have enough opportunity for mental health. We have very limited facilities. We have not been able to use one of our very best facility because of the low census. There were just three to four patients in the facility so we had to look for a new facility.

Related to learning, a participant suggested that "placements make a difference in learning. It gives students an opportunity to apply theoretical concepts to practice." Gull concurred: "Sometimes faculties are assigned to different units for clinical, and these units may not be familiar with the clinical instructor. If the instructor is not comfortable, it has a negative impact on students' learning." Another participant gave an example:

> If I am comfortable in cardiology and not in oncology, and if I am sent to oncology that would definitely hinder students' learning. Although I have some knowledge, I would have to update myself before I would feel adequate. If a faculty member is comfortable in a particular unit she can facilitate students' learning in a better manner.

This respondent made the point in the interview that the placement should reflect the curriculum design, and another participant reflected on this:

> It depends upon the curriculum design. The teaching strategy changes depending upon the nature of curriculum. Presently we are following the medical system. Clinical is an essential part in the medical system; if we are teaching students regarding oncology we make sure that they go to the oncology ward for their clinical experience. . . . Yet we don't guarantee them that they will get the patients with all the diagnoses they have learnt in the theory class but at least they will get the exposure.

A senior participant asserted:

> I think the role of placement is important and we should select placements according to the level and according to the knowledge of students. I have observed that second year students are going to the psychiatric wards. The theoretical content about psychiatric nursing is covered in the third year according to the curriculum. So what is the use of sending them in the second year without theoretical knowledge?.

Zoya remarked:

> Traveling time is a problem. If we choose a placement far away, it may take one hour to go and one hour to come back, which reduces the clinical time for actual practice. Thus, one needs to consider lots of things before selecting a clinical placement for the students.

Government Institution

At the two schools of nursing selected for this study, the students had their clinical experience in house, which means that they did not have to go to another hospital. Two participants shared their views. Maria explained:

> Our students do not go to other hospitals for their practical experience. We have lots of patients coming from all over Sindh for treatment. There are no charges to health care, we get lots of patients especially from the rural area that come to seek health care. Thus, getting patients for students experience is not a problem. In fact, most of the patients in the hospital are left unattended due to a lack of nursing staff.

Najma added, "Even if we want our students to go to other hospital for clinical exposure, we would be unable to do that; . . . we have no transportation. . . . To arrange transport one needs finances; getting approval for this request is unrealistic."

Placement is a significant factor in facilitating clinical learning for nursing students. The responses of the participants from the private organization were discussed first, and then those of the participants from the government sector.

Stressors

Question 12: What are different stressors a clinical teacher faces in the clinical area?

This question was intended to evoke general responses from the participants. It was interesting that most of the concerns were the same as those reported in the Western literature. The major stressors that the participants identified in the interviews (Table 12) involved the student-to-faculty ratio, the increased workload, the environment, gender issues, safety, and ethical concerns.

Table 12

Themes That Emerged on Stressors in Clinical Teaching

Themes	Government institutions: A & B (n = 15)	Private institution (n = 15)
Student faculty ratio	1	15
Work load	6	12
Evaluation	None	15
Administrative roles: mentoring	2	2
Lack of resources	15	-
Gender issues	3	5
Safety	-	9

Student-to-Faculty Ratio

Sixteen of the participants pointed out that the large number of students in a clinical group is a major influence on students' learning in the clinical area. All of the private sector participants agreed. One of the government participants bemoaned the fact that "we have two clinical teachers for a group of fifty-six students. It is difficult to keep track of their performance. I go once a week to the ward to inquire about students' performances from the staff nurses." Susan concurred: "There are different stressors for nursing faculty. The number of students to monitor in the clinical area is just too much." She added, "Being a clinical teacher, one is not exempted from the other responsibilities, classroom teaching and committee work." Another participant said:

> I have about eleven students. My clinical day is for six hours; it's very difficult for me to reach all of them. It is difficult to supervise them at the same time. I do a general round to see if every one is okay.

Meena sharing the same concern stated:

> Having twelve to thirteen students in the clinical area it is difficult to give the same attention to all of them. Although I try to manage time it's difficult to supervise all of them. Sometimes one or two students are not supervised and if these students are those who need more attention I feel stressed and guilty for not providing proper guidance.

Bina pointed out:

> One of the major stressors is having eleven or twelve students, all having different learning styles. A stressor is how can I be flexible to incorporate 12 different learning styles? I am a single person and I have my own style of teaching. I have to mould myself according to my students. I cannot generalize the teaching approaches for every student.

One participant simply stated, "The ratio of one faculty to eleven students is too much for clinical." Another responded similarly: "Having thirteen students in the clinical area is too much. There is a tendency for a student to be missed. One cannot take care of thirteen students at one time." Hamida reported:

> I have eleven students, divided in three groups, placed in three different clinical areas. I find it difficult to supervise in three places at the same time. The students tell me "Miss, you have to come to us" and another group also needs me, where to go first?

In addition, "Sometimes, it is not possible to go and observe skills. I have to request ward staff to supervise my students while they perform the skills and later on I take the feedback." Gull mentioned the importance of having good IPRs with the staff to facilitate students' learning:

> I take eleven or twelve students to a ward for their practical experience. Students are expected to take care of the patients including giving medications and performing skills like sponge bath. Sponge bath is a basic skill and this has to be done early by 9:00 a.m. If it is not done before the doctors' rounds, the head nurse and doctors complain that our students did not complete their tasks on time. Being a clinical faculty one needs to hear criticisms, but one thing which I have noticed is that if a faculty has a good interpersonal relationship with the head nurse or staff nurses in the ward then there are no such problems.

Workload

Increased faculty workload was a concern of 60% of the participants from both types of institutions. *Workload* refers to the different responsibilities of a nursing faculty as indicated in the job description. However, the concept of workload was slightly different for the faculty working in the government institutions. Najma said:

> I know even though I don't go with the students for clinical still there is a lot of work to be done at school. For instance if I am the class teacher of Year I, I have to keep a record of students' attendance. I also go to the ward to check on the students' performance on the clinical once a week. So, it is not easy. In the government sector we have no administrative assistant so one becomes the administrative assistant. It becomes worse during the examination period when one fills students' records.

One of the reasons for the increased workload was pressure from the administrators, and the other reason was related to the limited number of nursing faculty members. The participants from the private organization shared their views below.

Zohra complained, "We go once a week to clinical. Each week we have theory classes, plus clinical that requires time to prepare." Another added, "During the clinical week, one whole day is spent in clinical. Then I am also teaching two other courses. I have so many assignments to mark, most of the time I am taking them home for marking."

Another participant said, "My concern is about time, after getting tired with the clinical work." Susan said, "Each portfolio takes two-and-a-half to three hours to read. Where would I get that time? Time is a problem." Similarly, Hamida stated, "It becomes very difficult to manage time, to prepare for class, to do corrections, and to perform the other leadership roles. I am the chairperson of the committee also. To accomplish all tasks is difficult." Meena lamented, "I cannot write detailed anecdotal notes. I just write a little so that I know where the students are at." Zoya addressed the importance of feedback: "Our clinical is only one day. If the students can get feedback on the same day, then they can work for the coming week. This can only happen if faculty has time to work on the students' feedback." One respondent pointed out that "checking clinical assignments and giving students feedback takes so much time." Salma stated:

> When I am in clinical I do not know what is happening in the school. I am totally out. The whole week the faculty is in clinical, she does not get involved with any thing as there is no time. You start from the morning and you come back have postconference or give them time to practice skills. I do not have time to open my e-mails or internet for the whole week. When coming back the first three days, I have to update myself. I strongly feel it is very difficult for me to meet my other responsibilities.

One of the participants from the private institution identified students' workload as a concern and expressed her views: "There is so much to write that the students are unable to provide patient care, but this tends to be the requirement of the course." Another said, "There is too much of the paper work for students and faculty. I don't know how much students are really learning form this written work."

Ruqia commented on the faculty's workload: "Checking assignments is another stress. One has to read each and every assignment thoroughly in order to provide them feedback"; and Gull explained:

> One needs to finish the given content before the student moves to the next clinical rotation. Most of the time I am worried whether the students get the opportunity to practice the skills enough. We have skills like catheterization, colostomy, dressing and these are bigger skills which take time. Having thirteen students to perform all the skills is time consuming.

Susan admitted that after completing her master's degree, "it is hard to come down to the level of the students." Another senior faculty from the private institution feared, "I feel I may do something wrong. I may not be able to work properly." A participant shared her views: "What if students ask something that I do not know?" Another participant said, "I can't say, 'I don't know.' What are students going to think about me?"

Evaluation

Evaluation is also addressed in question 10 with regard to grading. Zoya noted the challenges of evaluation:

> I have actually not been able to overcome all of my challenges. I am still into it, and the major thing that I am still facing is evaluating students' performance in the clinical area. It is very difficult for me to put a student on a learning contract. Last week I had a student on a verbal learning contract; even after giving two chances the student was not able to finish her contract. I had to put this student on

> a written learning contract. At that time I was thinking perhaps it is me who is not able to evaluate that student properly. So, I discussed the scenario with a senior faculty for their advice. So, evaluation is not easy, and I am still learning. The senior faculty member around guide me and explain what they would do if they were in the same situation and then I try to do what they suggest.

Farida felt that "evaluations are challenging for nursing faculty. One has to make sure the evaluations are objective. It is difficult for a faculty to fail a nursing student because one needs all the documents to support the case, which is impossible."

Administrative Roles

One of the less vocal participants from institution B referred to the role of administrator: "The management needs to be supportive." Maria shared her experience:

> When students are in the ward for clinical experience the staff nurses are concerned about their work, and they do not facilitate learning. Thus, most of times we have arguments with the ward people that students are there to learn and not only for performing duties. Therefore, most of time is wasted in arguing with the staff nurses discussing the students' role in the clinical area.

Zoya, from the private institution, mentioned the need for a mentoring system:

> In our school because the turnover is so much, we are getting a lot of new faculty. We have introduced a mentoring system for these faculty. They are assigned one mentor for period of a six month. The mentor goes with the faculty on the clinical area as a support system, so they can ask questions or discuss any problem they have in the clinical. The project is in the infancy state. It started about two years ago. We started piloting with two faculty and we continued using those two pilots. We have two phases, one was the role modeling phase, in which a novice faculty goes with a senior faculty and observe what she does, and how she does it, and learn from her. Then we have the shadowing phase, where we go and see how they are doing the clinical teaching and we give them feedback. When we were told that there would be some mentor who would be coming and observing as shadowing us, I was not willing because I had a feeling that I would be taking my students to the clinical area and then again I would be having a faculty, who would be supervising me, so won't that give an impression to my students that I am a novice faculty and I am still under training, but then as the relationship went on, I felt that I was lucky enough to have a very good facilitator. It is a friendly relationship; I have not really felt threatened in anyway. It was really a motivating factor. Initially I used to go very rarely to her, like once in a month or so, but now I go to her every week. I see her, and we have a good discussion on my theory

> classes, clinical classes, pre and conferences and she gives me a number of ideas, by which I am actually able to conduct my conferences very well.

Meena added her positive comment on the environment:

> The work environment is not a stressor for me. I have already worked as staff nurse; however, now working as clinical teacher it is difficult for the ward staff to accept me as a clinical teacher. Sometimes the ward staffs still consider me as a staff and ask me to do certain tasks which are not in my capacity.

Lack of Resources

All of the government participants identified the lack of resources to facilitate clinical learning as a source of stress, as evidenced in the responses to question 16. One participant complained, "We have a lack of equipment to perform basic skills." Mohammed agreed: "We don't have equipment to perform skills on the patient; the result in a stress for students and faculty clinical teachers." Another participant emphasized this point: "The major issue is lack of resources." Farah elaborated on limited resources:

> We simply do not have resources [financial and human]. How can you teach basic skills such as hand washing when you have no water facility? The same situation prevails in the hospital; where the patients do not get bed sheets, most of them lie on the mattress. In most of the wards there are no screens, how can you provide nursing care to the patient in such a condition?

One of the participants suggested:

> There are certain things we can work around, but there are certain situations one cannot ignore. Considering the immoral practice in health care one feels helpless, one cannot do anything. If I talk to physicians about the concerns, they ask what do you know about my work?

Salma, from the private sector, gave an example of how the lack of aseptic technique is a major problem: "Professionals do not have the concept of sterile dressings." Susan shared her experience:

> Once there was a patient who had a sarcoma and scheduled amputation. His father was so upset hearing the news I counseled him. I went to the doctor and asked him to explain to the boy what is going to happen to him. A seventeen-year-old getting an amputation, and the doctor just turned me down, and he said, "Why are you interfering? Why are you bothered? Let his leg get cut! Why are you so upset?"

She added, "In clinical one comes across many issues not just related to student learning, but situations like this. It is so hard sometimes to work with them, change their mindset."

Gender Issues

Gender issues were a concern, especially for the government faculty members. Anisa reported:

> Being a female and coming early in the morning to work is trouble. The bus system is also not developed like in the West, the buses in the morning are always full and never on time. Safety is also another problem in public transport. Getting to work at seven o'clock is problematic for me. I have to cook for the family, get things ready for children to go to school. For those of us who do not have personal transport it becomes a big problem.

Another participant from the government sector talked about have to balance two lives: "Being a female and balancing professional life and home life is challenging. There are many roles one has to perform." Najma highlighted another gender issue: "Bringing change is very difficult in a culture which is dominated by male power." Maria felt that "to understand the culture and then try to integrate what is happening in nursing is very difficult." Zoya explained, "My students come up with personal problems. For example, they are not able to concentrate on the clinical area because they were unable to sleep because they had some quarrels in their homes." Susan stated, "The major hindrance for students' learning I have noticed is emotional stress."

A participant from the private sector referred to secondary stressors: "Besides excluding oneself from the clinical setting, there could be some secondary factors that could actually affect students' performance at the clinical." Another respondent from same institution questioned:

> If one's basic needs are not met, how would one be able to help clients to reach to the optimum level? If I am worried about my husband or children, it would affect my interaction with the students. Learning may be compromised unless the issues are solved. I do not think one would be able to help the students reach the optimum level of functioning.

In Pakistan, childrearing and upbringing are seen as the responsibility of the mother in addition to the other household work. One participant from the private institution expressed her frustration: "The condition of the daycare is miserable. There are so many children in a small place. This adds to my stress."

Safety

Nine participants from the private sector considered safety a major concern, not just students', but also patients'. Zoya acknowledged, "Students' safety in the clinical area is one of my worries. At times I don't assign them to the private rooms." Susan said, "Students' safety is a very big concern to me. Sometimes I ask two students to take care of one patient." Other respondents pointed out that "I have to ensure safety of nursing students and patients because we are responsible for them, so that's another stressor" and that "I have to be careful when students select their patients. Patients come from various backgrounds, and the patient selected must be willing to welcome a student as his/her caregiver."

Farida, from the private organization, commented on the political condition of Sindh:

> One is not sure about the situation, when you come in the morning and hear there is strikes of transportation how can you go for clinical which are outside the facility?. The surrounding environment has an impact on the students' learning.

> Parents do not send their daughters to clinical if there is a problem in the country. We have a make up week to complete the course objectives but how much can be covered in one week?

Question 12 dealt with the different kinds of stressors that a nurse educator faces. The participants identified seven: student-faculty ratio, increased workload, evaluation, administrative roles, lack of resources, gender issues, and safety.

Influence of Culture on Nursing

Question 13: Do you think culture has an influence on nursing in Pakistan?

This question explored the impact of culture on the nursing profession. Nursing in Pakistan is still struggling to gain respected status in society. Three aspects were addressed: students, faculty, and institution. Susan defined *culture* broadly:

> Dealing with students coming from different cultures is a challenge for nursing faculty. Nowadays the students are not only from Pakistan, but also from outside Pakistan. Every student brings in their own ethical and moral values e.g. their dressing style which includes the way they sit in the class and the way they communicate with others. As a teacher we have to deal with all students in the same way regardless of where they come from. I think that it is not fair for example when we are doing skills like bed bath and students coming from Northern areas have difficultly in demonstrating this skill on their peers. It is difficult for them to demonstrate the skill because they are coming from a conservative environment.

Another participant said, "Students bring with them their culture"; and Salma concurred: "We have to respect cultural values; one cannot force things on students. Now with the increase of students coming from Tajikistan and Afghanistan, they bring their own culture."

Culture has a great influence on the nursing profession, as a participant in the study stated. Circumstances have improved over the years, but not to the extent that a young woman can proudly say, "I am a nurse." However, some factors have enhanced the acceptance of the nursing profession in Pakistan, as indicated in Chapter One. The responses are categorized in three sections: perception, higher education, and male dominance, as depicted in Table 13.

Table 13

Themes That Emerged on Influence of Culture on Nursing

Themes	Government institutions: A & B (n = 15)	Private institution (n = 15)
Perception	11	3
Higher education	3	2
Male nursing	2	-

Perception

With regard to the perception of nurses in the country, the participants from the private sector were much more positive than the government-sector participants were, as is evident in a comment from Farah from the government sector:

> One does not know what kind of perception the patient [male] is taking home with him when he is discharged from the hospital. At present he is sick, so he is accepting the role of female nurse. Once he is fine and discharged from hospital, it is not necessary that he would have the same positive perception about the nurse.

Five participants from the government sector were concerned about the image of nursing, and one admitted, "I would never want my daughter to become a nurse." Maria shared her personal experience:

> In my neighborhood there was a conversation going on for engagement, but as soon as the family knew that the girl is a nurse they simply refused for this reason.

> On inquiring the reason the parents gave was that they did not wanted their son to marry a nurse. Nurses do not have good reputation in the society.

Another participant questioned, "How do we portray ourselves in our community? If we abide by cultural values and display a positive image, then maybe things will be different. Society will accept nurses and the nursing profession readily." Zoya, from the private sector, reasoned:

> It all depends upon how we see the nursing profession. When we wear a white uniform and go in the ward, how do we feel about the dignity of the white uniform? If one feels bad, then this feeling would not allow him/her to grow personally and professionally.

One participant from institution B expressed her views: "At times it is sad to say that we don't consider nursing as a profession." A participant from the private sector voiced her opinion on the role of the media in portraying the image of nurses:

> Nurses are not looked at positively in the society. I believe the media contributes a lot to the negative image. The Urdu dramas have pictured nurses as being rude with the patients, wearing untidy uniforms, and having limited questioning skills.

Meena complained:

> The image of nursing has changed over the years, but not completely. Patients believe what doctors tell them is always right and that nurses have limited knowledge. Thus the patient feels there is no use to consult nurses for advice. The reason behind this philosophy is that they have seen nurses doing technical work only. By technical work, I mean giving medications and injections. Nurses have to be more dynamic to be accepted in the profession.

Najma, from the government sector, provided an example during the discussion:

> I think culture has a lot of impact on nursing profession. I can give you an example. Two weeks ago an individual came to the school complaining about a nursing student and insisting that we terminate this student nurse. I asked what had happened and he told me that he asked the nursing student to draw a blood sample which she refused. When the nursing student was asked about the event she said, I refused and informed him that a student nurse is not allowed to draw

> blood samples but he would not listen to me. This is because people are ignorant of the role of a nurse.

One of the government participants shared her views:

> I have been working in this school since 1997. If I compare the changes in nursing which have taken place, there is a positive change; nurses are more accepted in the society. Sometimes the patients would come and ask, "Sister, can you help me out? The doctor said something, but I could not figure out what he was trying to tell me. Doctors are always in a rush."

Higher Education

The participants linked higher education with the image and status of nursing in the country. Susan shared her perception of BScN students:

> The graduates are taking up the leadership roles in government and private sectors, which is contributing towards improving the status and image of nursing in the country. People are trying to recognize nurses for their services in the community. We are different, and we are making a difference, and this is important to me.

Mohammad noted:

> One of the nursing faculty in the government institution after completing a BScN is now working at the Pakistan Nursing Council. It is important that educated nurses get the opportunity to bring about changes for the betterment of the nursing profession. Another government BScN nurse whom I know is now the principal of one of the schools of nursing.

Adding to the argument, Ruqia said, "Now having the BScN program in our country, I hope educated nurses will bring about change in the community. Recently, our nurses have even registered with UKCC. So Pakistani nurses are found everywhere." Farida highlighted the changing mindset that accompanies education: "The culture that the doctor knows more is there, but slowly with higher education coming in the country, the mindset is changing." However, one of the participants from the private sector pointed out, "In our profession most of the time nurses are not allowed to perform the task which they are supposed to perform. There are a number of reasons involved behind this approach. Is the male dominance an important one?"

One of the less vocal participants from government institution B explained:

> All nurses in Pakistan are not lucky to get the opportunity to go for higher education in nursing. I had the opportunity to be offered to go for study in Australia last year. Before I was going to leave for Australia my mother-in-law got admitted to hospital with a stroke and ended up being in the bed. Because of that I had to refuse the opportunity. Now that she is well, I am taking some courses from Allama Iqbal Open University.

Razia, from the government sector, believed that "we need qualified nurses in leadership positions."

Men in Nursing

I asked the two men who participated in the study to comment on the role of men in nursing. Mohammed expressed his opinion:

> I think nowadays the perspective of having men in nursing is changing. In the profession which used to give the impression that they were reserved for men like engineering now you see females working side by side with the men. The same applies to the nursing profession today, men and women work together for the patient care.

He added:

> I think people understand the role played by the male nurses in our society. However, we have to prove our position in the society by demonstrating skills and knowledge. If we do then men will be accepted in society; nowadays, there are many male nurses world wide and they are acceptable. In Pakistan, we have less of a concept of males in nursing but gradually the society will appreciate male nurses.

The other male participant said:

> Initially, I had difficulty with my in-laws to accept me as a male nurse. They would question me about what I do with the female clients and so on, . . . but now they are supportive of nursing. I have always felt proud to be a male nurse.

Furthermore, "Now I can realize how challenging it is for a female, even though I am male. At times it is difficult to satisfy a male patient in our culture." At the end of the interview he said, "If I have a daughter I surely want her to become a nurse."

This question explored the impact of culture on the nursing profession. Culture was discussed on three levels—students, faculty, and institution—and the participants in the study saw it as having a significant influence.

Theory-Practice Gap

Question 14: What are your comments on the theory-practice gap?

This question reflected some of the critical aspects of nursing practice. Only one participant from the government institutions responded to the question; the rest replied that they have limited information on the theory-practice gap because they are not involved in taking students to the clinical. This participant said:

> We need to develop skills where we can promote critical thinking and problem solving skills among nurses. We have to move away from rote learning to more advanced learning [critical thinking]. We are still using the old traditional approach to teach the students, that is lecturing. The teacher reads the notes, dictates the notes, to the students to finish the course on time.

Zohra, one of the participants from the private institution, expressed her understanding of the theory-practice gap:

> I feel faculty should learn how to integrate theory into practice. When the faculty member prepares for clinical she needs to find the opportunities to incorporate the content in the clinical. Secondly, she needs to be consistent in her approach. For example, if I do it and you don't, then the students miss out, so there should be a consistency.

Susan commented:

> It all depends upon the level of student and exposure of faculty. If the faculty has experience and exposure she will help students to integrate theory into practice

> and try to implement things which they have learned in their theory. But if the faculty is not sure how to do it, and students are not motivated, it is difficult to integrate. So yes there is a gap partly because faculty members are not up to date in the knowledge, have limited exposure on how to implement the concept and how to increase students' interest. We can't say that it is all faculty fault, because there are certain students who are careless and who do not want to work. I want to see the content taught being implemented on the patients but that needs expertise that does not come overnight.

Salma was more specific:

> I cannot generalize; it depends upon the individual faculty and partly depends upon the system. For example, if I talk about my course, there are three faculty members who are teaching with me. Most of time I don't know what content they have covered in the class, so how can I integrate what they have taught in class in clinical.

Zoya gave an interesting perspective:

> I would say that the theory is a very important component. What I do in my clinical area I integrate all the subjects that have been taught. For example, what is being taught in the community at this point of time, I try to integrate one of those aspects in my clinical learning. For example, very recently, in community, they were taught about water and sanitation. Thus, in water and sanitation, one of the important topics is water born diseases, like typhoid. Consequently, if the patient in the ward is suffering from typhoid, we would discuss about the disease in reference with the recent literature on the topic. In this way students are able to relate the theory components of that particular subject on a broader aspect.

Meena reflected on this important aspect: "The theory-practice gap does exist to a certain extent in our culture. One needs to question the reliability of the existing western literature. Nursing has been existing in our country for ages now, so what is the problem?" She elaborated ,"One needs to critically examine the Western literature. Maybe we do not have a theory-practice gap. More research is required in this area." Another believed that there is no theory-practice gap: "I feel our nurses use more critical thinking skills as they work with limited resources to meet the health care demands."

According to Farida, "There would be a theory-practice gap until service and education will work on the common goal." One of the participants questioned, "Theory-practice gap? How would one know if there is a gap and how much is the gap?" Ruqia responded:

> The discussion of theory-practice gap has been existing in the nursing literature for ages and it will continue to remain a hot topic as nursing is progressing so fast. It is difficult for nurses to keep up with the pace.

Three participants felt that a gap exists, but "how can one over come it? It is just impossible."

In this question the participants reflected on their understanding of the theory-practice gap in nursing. However, it was difficult to determine whether they understood the term or not because in the government institutions the staff nurses do the clinical teaching. Further research on the subject would be helpful to nursing education.

Continuing Education

Question 15: Do you think there is a need for continuing education sessions for clinical teachers? If yes, on what topics?

All of the participants responded positively to the question about the need for continuing education. Because I asked it at the end of the interview session, the responses were limited response, which possibly indicated the participants' fatigue. Bina thought that

> Education brings changes in one's approach toward teaching and learning. Before I was very much skill oriented. I used to be in front and the students used to follow me in the skills. After enrolled in a master's program I have been working with students in meeting their clinical objectives. I am not ahead nor are they behind. We both are working together with each other. They have the liberty to choose the patients they want but it has to be within the given boundaries of the curriculum.

Najma stressed the importance of planning for the clinical: "He or she should plan the activities for clinical. For example, which day the faculty has to teach third year or first year students and what procedures he/she will teach prior to clinical experience. Teaching should be planned."

Zohra believed in "planning the activities for clinical ahead of time so that I am not running out of equipment at the last moment." Salma complained, "You may plan to show the video, but due to limited resources, the preference is always given to the medical students, not nursing students."

One participant commented, "The concept of clinical teaching barely exists in Pakistan. There are no courses or continuing education for nurse educators on how to facilitate students' learning." Mohammed stated that "at present I am a clinical teacher, but I never go to the clinical; I do classroom teaching." Farah suggested, "We should have refresher courses. All the faculty and nursing staff should meet once a week to find out what students are doing in the ward and try to find out strategies which would facilitate their skills." One of the male participants contended, "We are very backward in clinical teaching; if you visit different hospitals, we don't have bedside teaching. It is important that we have clinical teaching in hospitals." One of the participants from the private sector proposed, "All clinical teachers should work in the hospitals to update their skills."

Zoya said, "I would suggest the Pakistan Nursing Council should encourage their faculties to go for at least two to three weeks of faculty practice, because without practice it is difficult to perform skills on the patients confidently." Susan cited her experience in the private sector:

> We have a committee which promotes clinical teachers to share their problems and come up with the solutions, which are based on the research literature. This needs to be integrated with the non- governmental organizations. They need to be included in whatever we are doing. So that they understand what is clinical teaching. If they do not understand what is clinical teaching naturally no one will start clinical teaching, so, basically communication between this organization and other organization is required, to bring about a change in nursing.

Meena maintained that

> Faculty practice is very important. If I do not know what is going on in the ward, what are the recent practices, then what am I going to teach when I take my students for their clinical experience in the ward.

The participants from the private sector focused on faculty practice as a resource to enhance clinical skills. One of the participants from the private sector said, "I think the whole aspect of clinical teaching has to be looked at." A faculty members from the private sector reported, "At present 5% of faculty time is allocated for faculty practice in the ward; that is, fifteen days in the year are allocated for a faculty to work in the ward." She added, "I think that it is not realistic for faculty to update all the skills in fifteen days." Hamida, from the private sector, stated:

> The faculty should have updated knowledge to help students learn the reality of practice area. A teacher should transfer the essential attributes to students for learning, although it's difficult but the faculty should try to do it. I would like to see faculty facilitate students' learning.

Gull expressed her concerns about resources:

> I think our teachers should be qualified in each and every aspect of nursing content. It is important to have resources available such as a demonstration room and the equipment required for practice; these things should be available in the School. If proper things are not available, how is the teacher going to teach her students according to standards. I think this is the main problem of most of the schools and it should be overcome.

Anisa asserted, “There is enough of a workload of teaching by itself. Before coming to the school I was a staff nurse; I did manage fifty patients on my own.” Razia, a senior faculty member, asked, “I have passed my nursing a long time ago. There have been changes, but if the institution is not allocating time to update skills, how is one supposed to take time to practice?”

The participants identified a need for continuing education in the topics listed in Table 14, which summarizes the responses of the government and private-sector participants on the need for further education; they did not elaborate on the topics. For example, one participant said, “I need to know more about pre- and postconference.” I asked what this person wanted to know in particular, and the response was “All.” Patient care was another topic that the participants mentioned, but again they did not provide details. For example, one said, “I like to be confident taking care of patients admitted to hospital” and “I would also like to justify the care provided based on the scientific evidence and share this with the students.”

Table 14

Continuing Education

No.	Topics	Private	Government
1	Objective and timely evaluation	8	3
2	Planning for clinical: managing time and facilitating students based on clinical objectives	5	1
3	Teaching strategy: pre- and postconferences	6	4
4	Writing anecdotes	11	-
5	Providing constructive feedback.	12	7
6	Patient care: providing competent care (technology) and multidisciplinary approach	14	8

Gull commented, “I would like to learn more on how to use the questioning skills to enhance students’ learning,” and Zoya identified her learning needs: “I would like to practice and learn more about the objectivity of the clinical evaluation.” Some participants had listed topics on a piece of paper, which they read.

Clinical Teaching in Pakistan

Question 16: How would you like to see clinical teaching in Pakistan?

This section explores the process of clinical teaching in Pakistan, and the respondents had various suggestions. Eighteen indicated the need for clinical teachers to have specialized skills in teaching practical skills to nursing students. All participants from the government institutions noted the impact of limited resources on facilitating clinical teaching. A very interesting finding that is worth mentioning is that some of the participants had had no exposure to or any idea about the role of the clinical teacher. Therefore, some of the participants responded generally based on their experiences.

The responses to this question can be divided into four major categories: (a) administrative issues—collaboration between education and service and curriculum implementation, (b) the role of facilitation with regard to students, (c) the characteristics of the clinical teacher (this category was incorporated into the discussion on question 4), and (d) a miscellaneous category that includes the concern of the nursing profession about its recognition.

Collaboration Between Service and Education

In the interviews 21 participants considered collaboration between nursing education and service in enhancing the clinical experience of students as the most critical aspect. Nine participants agreed, for example, that “it is important to have good relationships with services for students' learning." I asked them to comment on the current relationship but received no response, but Maria believed, "If there is collaboration between the school and the hospital it helps the students' learning and practice." Mohammed noted the reality of service:

> Service is concerned about work; the staff does not care about students' learning. The administrators of the hospital only care about their work, and they don't care about the students' learning. I suppose this is not their responsibility; they don't monitor any students, and they don't have any monitoring system.

He questioned, "Should they be monitoring nursing students?" Susan suggested:

> I think there should be a forum in which the heads of different departments from the hospitals should meet with the educational administrators to discuss how these two departments [education and service] can help each other. The relation has to be healthier in order to facilitate students' learning in the most effective manner. We should be able to learn from each other rather than criticizing.

Zoya said, "If we want nursing to progress, education and service have to work together for a common goal of quality patient care."

Government Organization/Limited Resources

Mohammed referred to the limitations of the government institution:

> In most government departments the problem of financial and human resources exist. The problem in government authorities is that they do not take an interest in the uplifting the profession. The other issue is weak leadership; they are not competent as they don't know how to communicate from top to bottom and thus cannot manage things properly.

Razia wondered, "How can you teach skills like dressings without equipment such as forceps, gauze and antiseptic solution?" and Bina concurred:

> Teaching about the alternatives ways of meeting health care is critical. For example, if we talk about the sterile technique we do emphasize it but what if we do not have the resources available. I remember one of the experiences I had with one of my students. The student was looking for a catheterization pack to start the

> procedure. It was difficult for me to explain how to perform the procedure without the pack. Helping students to learn within the limited resources is a big challenge for the nursing faculty.

Anisa, from a government institution, supported the need for resources: "We need materials: the necessary equipment to teach students how to perform skills." Mohammed said, "We don't have a demonstration room where we can practice so the students can gain confidence by practicing." Susan, the senior clinical teacher from the private institution, contended:

> When we go to semigovernment and government hospitals, there are many factors which one needs to consider for clinical teaching. For example, if we utilize a clinical teaching facility one needs to look into the relationship between the staff and faculty, the availability of the resources, and the opportunity of performing the skills on any patient. Having the chance to perform the skills on the patient is a major concern for nursing faculty. In other hospitals you can get a variety of patients with different diseases and cultural backgrounds; students can take care of patients and perform skills. In this case faculty is more relaxed; they do not have to struggle to identify the patients for the students' learning experience.

Curriculum

Five participants from the private sector, including Zohra, shared their views on the importance of periodical curriculum reviews and incorporating change while teaching said:

> We teach nursing students about the latest procedures which are in the literature. However, most of time that literature can't be used in the same way in the clinical area. The faculty needs to see the needs of country and modify the curriculum accordingly. The curriculum may not change within three to four years; however, the identified content needs to be incorporated into the curriculum. If the content is not taught, it results in insufficiently prepared nurses. If new things which are in the ward are not taught to students, how are they going to be competent nurses in the future? If we are teaching students outdated content then what is the point of teaching them. For example, we do not teach students to test blood glucose by glucometer; instead we use old traditional approaches by testing urine through chemicals. But nowadays glucometers are available in all hospitals; this is advanced technology. So, we need to see what do we teach, what is available and accommodate accordingly.

Zohra added:

> The Pakistan Nursing Council needs to review and update the nursing curriculum as it is still expected of us to teach blood sugar testing by using old methods. We have no choice but to teach them as they are tested by the Sindh Nurses Examination Board.

One of the participants mentioned her concern: "I got limited understanding about the curriculum design during my preparatory phase. I have had no problem so far. I have been reading books on curriculum; . . . [it is] not easy."

Facilitation

Farida reported her views on facilitating clinical teaching: "I feel students should be given some time for independent practice to gain confidence." However, Farah, from the government institution, complained, "No teacher goes with students to the ward. There is no checking system of what the students are doing. Most times students go home after attendance. There is nobody to whom they have to report." With regard to the same issue, Mohammed pointed out, "Students learn on their own without guided supervision, resulting in learning some basic procedures and nothing else. That's why nurses have poor knowledge, because their critical thinking ability is not developed."

Gull, described her experience:

> I have not gone to many hospitals, but during my student life I had clinical experience at certain hospitals. If you go there, there is no proper system of clinical supervision for the students. The students in the morning and evening work by themselves. There is no faculty supervision. What I have seen is that the students are there and nobody is there to look after them, and they are providing care on their own and they are learning on their own.

Recognition

Two government institution participants considered increasing the recognition of the nursing profession in the context of clinical teaching critical. Mohammed agreed: "In Pakistan, the nursing profession needs recognition. We can only improve if we get recognition not only from authorities, but also from society. This can only happen when nurses improve their knowledge in practical areas." Maria said:

> The major factor to me is the qualification of a clinical teacher. If I talk specifically for Pakistan, we don't have qualified faculty members who can be given the responsibility of clinical teaching. Qualification and experience are major factors to facilitate learning.

Conclusion

This chapter contains the analysis of the data, which followed a particular sequence to make it easier for the reader to understand clinical teaching in Pakistan. The total number of questions asked was sixteen. Question 1 considered the concept of clinical teaching, followed by question 2 on educational philosophy. Question 3 inquired about the models of clinical teaching. Questions 4 and 5 focused on the characteristics of clinical teachers and their comfort level in the clinical areas. Question 6 related to the clinical experience and the content expertise of the clinical teacher. Question 7 asked the participants about teaching and learning strategies, followed by Question 8, 9, and 10 on written assignments, pre- and postconferences, and evaluations, respectively. Question 11 explored the issue of clinical placement, and question 12 was concerned with stressors for clinical teachers. In response to question 13, the participants addressed cultural influences on nursing. In the next two questions, 14 and 15, they reflected on the theory-practice gap and the need for the continuing education, respectively. Last, in question 16 the participants shared their ideas on how clinical teachers would like to see clinical teaching in Pakistan.

CHAPTER FIVE:

FINDINGS FROM THE NURSING STUDENTS

This chapter presents the analysis of the data obtained from the nursing students in the three years of the diploma program. I conducted a total of 30 interviews with participants from both a private and government institutions and asked 10 questions on clinical teaching practices in Pakistan. The topics that are addressed in this chapter include the profile of nursing students, clinical teaching, the characteristics of the clinical teacher, clinical experience, teaching and learning strategies, written assignments, pre- and postconferences, clinical evaluation, stressors of nursing students, the influence of culture on nursing profession, and clinical teaching in Pakistan.

Profile of the Sample: Nursing Students

The total number of students who participated in the study was 30—15 from a private institution and 15 from two government institutions. The participants from the private institution were all females between the ages of 15 and 26. Three participants from the private institution were married with one child (0-3 years of age). The participants from the government institutions were between the ages of 15 and 19, and none had children. The greater age variation in the private institution will be discussed in Chapter Six. The participants from the private institution were all Muslims (10 Ismaili and 5 Sunni), and the participants from the government institution included Muslims (5 Shia and 4 Sunni) and Christians (6).

All participants from the private institution had passed Grade 12, and in the government institutions five had completed matriculation (Grade 10) and the rest had completed Grade 12. For the purpose of analysis, students from government institution A are referred to as SA participants, students from government institution B as SB, and students from the private institution as SP. I expected that the comments from the participants from the government institutions would be limited because of their limited exposure to the subject matter, but this was not the case.

I asked the student participants 10 questions. The following topics were addressed in the interviews: clinical teaching, the characteristics of clinical teachers, clinical experience, teaching/learning strategies, written assignments, pre- and postconferences, clinical evaluation, stressors of nursing students, culture, and clinical teaching in Pakistan.

Clinical Teaching

Question 1: What is clinical teaching?

The purpose of this question was to explore the nursing students' understanding of clinical teaching. Most responded that clinical teaching implements the concepts learned in class in practical situations with patients. They highlighted two factors that influence the learning of students in the clinical area: the role of the clinical teacher and the limited resources. The following section provides the narrative responses on clinical teaching, first from the students from the government institutions (SA and SB participants) and then from the students from the private institution (SP participants). An SA participant described clinical teaching as follows:

> Clinical means doing practically. Thus, clinical teaching means what we learn in the class has to be performed in the ward. Sometimes it is difficult to implement things which we learned in the class. However, we try to implement content learned in class in the ward. These difficulties are because of limited resources. Sometimes we do not have cotton balls to use for injections.

An SB participant agreed: "Clinical teaching is what we learn in classroom and demonstrate in the clinical." Another SA participant shared her understanding of the term:

> Clinical teaching is when what we learned in classroom is practiced in the clinical. What our teachers teach us from first year according to course outlines. They tell us what to do in the clinical area. We don't have any separate clinical teacher. What we learn is from nurses and doctors during our clinical.

One of the SB participants explained:

> Clinical teaching is learning and practicing on the ward. What one has learned in the classroom is to be applied with patients. The real challenge is when one works with limited resources. To give you an example, in one of my evening shift there was a patient who came from Sukkar [an interior part of Sindh] with a history of snake bite. He started to vomit and the doctor was informed and suggested to give an intramuscular antiemetic STAT. He was brought to hospital by the villagers, thus asking them to buy the injection for the patient was difficult. Then patient welfare (a place who gives financial assistance for patients who need it to pay their treatments) was contacted and finally the patient was administered the injection.

An SA participant said, "I learn a lot from the clinical experience; I mean, from practical work"; and an SB participant suggested, "Clinical teaching is learning about nursing care, for which one collaborates with other health team members to provide care to the patient." Three SB participants and four SA participants described clinical teaching as "learning on patients." They did not elaborate. Two participants from the government institutions did not respond to the question.

Narrative Analysis From the Private Institution

One SP participant responded:

> First we learn things in our classes then do these things practically on the wards. When the teachers come on round, they observe how we are performing our procedures. If we make any mistakes they correct our mistake by demonstrating

> the right way of performing skills on the patient. This is how we learn skills in clinical.

Another participant elaborated on clinical learning:

> Clinical teaching to me is the learning taking place in the ward and or in the community area. When we go to the community we are expected to apply the content we are taught for clients' betterment. One of the incidents which I can't forget of my community experience is while visiting an antenatal mother who was seven months pregnant. She had five other children all around her waiting for food. When I looked into the pot on the stove the food was hardly enough for one child. At that time I remained quiet as I did not know what to do. She looked at me and said, "It is just today that I have limited food. I did not go to work on the fields yesterday. Alia had diarrhea, and there was nobody to take care of her."

After a long pause the same participant added:

> Clinical teaching is integrating the content learned in the class to the practical area but one needs to assess the individual needs. In this situation I had ten topics in my mind for health education. But the priority one at that moment was how these five children were going to be fed.

One participant describing the process of learning said, "Clinical teaching is effective teaching. First the teacher gives the demonstration about the skills we need to learn such as vital signs. The second day we perform and get the sign off on the skills performed."

One of the participants viewed clinical teaching as follows:

> Nursing is the practical skills; a nurse needs to demonstrate the skills safely on the patient. We go to different hospitals during clinical to practice skills. Our teachers are all the time with us. They make sure we get the opportunity to show them the skills such as dressing, catheterization, suctioning and so on. Thus, clinical teaching is learning the skills in the clinical area.

One of the SP participants responded:

> Clinical teaching and learning is learning the skills in the real world. By real world I mean the ward. One learns the practicality of the skills in the ward because with patients, it is real experience. One may read how to do a

> catheterization but until it is not done with a patient one can't explain the experience of finding the urethra and inserting the catheter.

Another participant stressed the importance of practical skills:

> Students may read from nursing skills book how to do tracheotomy suctioning but until the skill is performed on the patient one does not understand the importance of hyperventilation. However, it is important to first practice the skills in the lab to gain the confidence to perform on the patient. Thus, clinical practice provides the confidence to perform skills on the patients.

One participant explained clinical learning as

> The learning in the clinical area, where a teacher is facilitating the learning process based on the learner's need. The teacher assesses the level of the students' performance and accordingly guides the students to attain higher learning goals. The competency of the students is challenged especially working with limited resources. For example, when we were on the medical floor we had two suction machines and one of them was out of order, and there were four patients who needed to be suctioned at the same time. Being a student my role was to assess the need of the patients and prioritize the care. In this situation the role of the teacher is to guide whether the decision taken by me is right. It is important to have competent clinical teachers to guide the clinical practice.

A participant claimed that

> Clinical learning is a difficult process. What one learns in the demonstration room and classroom needs to be practiced in the clinical, but the conditions in the ward are not always conducive to implementing the procedures learned in the classroom. Patients are uncertain; things may be different one day and completely changed another morning. This may be because of the disease, medication or past experiences. One of the patients shared her experience and said, she was admitted for a lumpectomy in the right breast which was about 2 cm. When she regained consciousness she found out that the surgeon had operated the left breast which had no problems. Clinical teaching is complex because one needs to know how to manage the needs (physical, mental and social) in different situations.

Six participants simply agreed that clinical teaching involves learning on the wards. One did not give an answer.

The aim of this question was to explore the students' understandings of clinical teaching. It was evident from their comments that they saw clinical teaching as an integration of theoretical knowledge into practice and as a complex process that requires critical thinking skills. They identified limited resources as creating barriers to students` learning.

Characteristics of the Clinical Teacher

Question 2: What do you think should be the characteristics of a clinical teacher?

The participants from the private institution based their responses to this question on their experience of having a clinical teacher in the clinical area, and the participants from the government sectors expressed a need for a clinical teacher; thus for this question they described the characteristics required in a staff nurse. The participants felt that a clinical teacher should be knowledgeable and skilful. Being able to role model, having facilitation skills, and being considerate of students' needs are additional characteristic that the nursing students identified. The following section presents the comments of the participants:

Knowledgeable

One SA participant asserted:

> A clinical teacher should be knowledgeable. If there is a problem in the clinical area, she should know how to handle it. Other than that she should be professional. She should go to clinical on a regular basis to supervise students` learning. In this hospital our nurses have no respect, so our teachers are afraid to come to the ward, but I believe if they are professional, they can handle things in a professional manner.

Another participant from the same institution said, "Clinical teachers should have up-to date-knowledge and experience so that they can answer student questions. Students should be encouraged to tell their teachers about their mistakes." An SP participant agreed:

> A clinical teacher should be knowledgeable, confident, and should have up-to-date knowledge. She should demonstrate skills first so that students can learn easily, and during clinical she should be with the students so that if a student makes any mistakes, she can correct them in time to prevent complications.

Another participant from the same institution cited the importance of using recent literature for clinical practice:

> A clinical teacher should be knowledgeable and skilful. She should be aware of the recent literature and incorporate it in teaching, so that students are aware of the advancements in nursing. She should act as a motivator for the students. Students work better if they are motivated. Students need guidance when a skill is performed for the first time on the patient. We are in a learning phase and need on going feedback on the performance.

> One SP participant identified having interpersonal skills as critical:

> A clinical teacher needs to be knowledgeable and skilful. I believe she also needs to have good interpersonal skills. When we go to the government hospitals we need equipment to perform the nursing skills. The cupboards are locked and the keys are with staff nurses. I have observed that the staff has given keys to only one clinical teacher. I believe this is because she has built a trusting relationship with them. Staff nurses are responsible for the equipment in the cupboard; they have to give an account at the end of each shift and if equipment goes missing, money is taken from their pay. One blood pressure equipment is about eighteen hundred rupees and a salary of staff nurses is 6,400 rupees a month [about CAD $110 per month]. In these situation what is she suppose to do.

In describing the characteristics of a clinical teacher, one SP participant noted, "A teacher is successful if she has the skills of imparting the knowledge and skills to the student. She may be new or having years of experience, students can make out which teacher is knowledgably and skilful."

Another SP participant reported a positive experience of administering medication:

> A clinical teacher should have the skills of facilitation. One of the experience which I still remember after two years is related to medication administration. I was supposed to administer medications to two patients in Block 116. That was

> my first experience of preparing the medications. After cleaning the trolley with an alcohol swab, I was standing holding my medication card. The teacher came and asked if I had checked the doctor's order, which I had forgotten in anxiety. I remember her checking the orders with me. Once the mediation was administered, she gently asked me about my experience about medication administration. She provided feedback with examples which was so enriching that I cannot forget this learning experience even after two years. We should have clinical teachers like her who can make clinical a life experience.

One SB participant gave her opinion, but did not elaborate: "A clinical teacher needs to be knowledgeable and skilful." Another participant from the same institution said, "A clinical teacher should be confident in performing the skills; this may be done in the patient area."

Another SB participant explained her positive view of her teacher: "Our teacher is good. During clinical she takes us to the unit for orientation; then she assigns our duties to different wards. Our teacher is working very hard to ensure that we meet clinical objectives." One of the SP participants shared her experience:

> My clinical teacher may be knowledgeable and skilful, but she is busy most of the time in meetings. She comes in the morning for a while, and then she disappears. In the postconference we share our experiences with patients and the care provided.

Humanistic

An SP participant detailed her teacher's humanistic characteristics:

> There is something special about [my teacher]. I always feel comfortable approaching her for personal or professional concerns. I appreciate her guidance; she talks with me in a friendly manner. She respects me for who I am, and this is important for me.

A participant from the same institution said:

> Clinical teachers should be considerate of the student's circumstances. There is so much written work in the clinical week that one does not get time even for lunch. The next day the clinical teachers wants the nursing care plan for the two patients

> and a functional health pattern form which is three pages. I just copy some of the data from the previous patients as there is no time to take the history on the same day. I can't understand what the purpose of so many assignments is. Is it to increase students' stress level in the clinical area?

An SP participant was grateful that, "in spite of being busy with a group of students, my teacher used to be there when I needed her." Another participant from the same institution described her teacher's friendly approach:

> A clinical teacher should be friendly with the students so that she can understand what students are going through in their life. Our clinical group used to have tea break with the faculty in which we would share our experiences, and that was nonthreatening. We could share our frustration with her. She would also work with us to provide care to the patient.

An SA participant felt that

> A clinical teacher should be one who can understand the needs and interest of the students. For example, if I am interested in working in Peds, the teacher should make sure the student gets the opportunity to work in the pediatric ward. I am planning to work in Peds after my graduation too. Although our teachers are very good when they assign duties they should take students suggestions as well. Other than that if students have some personal problem the teacher should be considerate and respect the rights of the students rather than exploit the student.

An SP participant referred to her second-year nursing experience on the pediatric ward:

> One of the clinical objectives was to demonstrate a baby bath. I was so afraid to hold the baby that I could not sleep at night when I had to demonstrate a baby bath. I was just thinking of the baby bath that night. My friend told me that if I don't perform the baby bath properly the teacher will put me on a learning contract and I did not wanted a learning contract. What would my friend think about me?

Ability to Role Model

An SB participant suggested that

> A teacher should be a role model for a student. She should tell students about proper dress code and professionalism. A teacher should follow first a proper dress code so that it creates a good impression on students. What a teacher says should first be implemented by her and then taught to the students.

An SA participant described the need for a clinical teacher:

> We have a shortage of clinical teachers. During three years we don't have sufficient teachers. We have only two teachers for Year I; in Year I we have 54 students. I believe Year I students require more guidance. We are new in the field of nursing and require assistance all the time.

An SA participant voiced the reality of the clinical experience:

> We don't have clinical teachers in the clinical area. It is the staff members who tell us what to do in the ward. They have years of experience working in the ward however they are too busy in the ward routines. They hardly have time to teach us. We learn by watching staff while they perform skills or sometimes we ask medical interns to explain things to us. Staff nurses have the practical knowledge of how to do it but due to limited theoretical exposure, they are unable to provide rationale for the intervention to the students.

An SB respondent suggested an alternative approach: "We don't have a clinical teacher, but teachers should have ten to fifteen minutes after clinical to ask each students about the learning experience. They should give us case studies so that we can learn more." The same participant discussed the role of staff nurses and physicians in educating nursing students: "The staff nurses and physicians teach us. However, due to limited time, they can't explain to us all the things in detail. We don't get proper training in the clinical area."

Another participant from the same institution stated:

> We don't have any clinical teachers; we have only subject teachers. They give us guidance, but they can't give instructions on the wards because they don't come on the wards. Other than that they have other school work to finish by 1400 hours like marking exam papers, and preparing the marks sheet. [Furthermore,] in the clinical area, we don't have any guidance. Even staff nurses don't have time to teach us. If someone is doing a wrong thing, nobody bothers to correct that student.

The rest of the participants from the private and government institutions did not respond to this question. I probed twice to elicit responses, with no success.

Question 2 focused on the characteristics of clinical teachers. The participants believed that clinical teachers must be knowledgeable and skilful to solve clinical issues effectively and guide students according to their learning needs, as well as humanistic.

Clinical Experience

Question 3: Do you think teachers with clinical experience have an impact on student learning in the clinical?

In response to this question, all participants from all of the institutions asserted that teachers with clinical experience have a positive impact on students' learning in different ways. Again, the participants from the government institutions referred to *staff nurse* instead of *teacher*. This question is divided into two sections: The first section presents the analysis of the comments from the government-institution participants, and the second part presents the responses of those from the private institution.

Government Institutions

In response to this question, an SB participant said, "I think a teacher should be experienced. If she has experience, she can understand the needs of students and can teach in an appropriate way." Another participant from the same institution agreed: "A clinical teacher should have knowledge and skills to facilitate learning in the students."

An SA participant also concurred: "Yes, clinical experience will help students learning in the practical area. The staff can guide students' in assessing patients needs based on the diagnosis." Another respondent from the same institution answered the question from a different perspective:

> I see this question differently; there is no clinical teacher with us in the clinical area. The situation is different; it is staff nurses with whom we depend on for guidance. There is no doubt that they are skilful in the practical work. I have seen staff nurses administering intracardiac drug which even a physician could not do in an emergency situation. There are lots of situations I can share about the competence of the staff nurses; one instant worth mentioning was when a staff nurse saved the life of the new born infant. The infant was cyanosed on birth and required intubation and this was done by the staff nurses, the doctor was unable to do it. Nurses working in these situations become skilful. Nevertheless, I am not sure about the teachers in the school whether they possess the same practical competency or not? The reason being we have not seen them working in the ward.

An SA participant added, "It is essential for a nurse to have theoretical knowledge; however, I believe if a nurse is skilful, that is more important in our culture."

An SB participant discussed the limited ability of staff nurses to rationalize the care given: "Most of the time when we ask staff nurses why this procedure is done in this way, the response is 'I don't know. This is the way I have been doing it.'" Another participant from the same institution contended, "I believe experience is power. When I use the term *power*, what I mean is that it gives nurses energy to work with the patient in an efficient manner."

Three participants nodded their heads when I asked this question and did not say a word. Five other participants answered affirmatively; for example, "Yes, if a staff has clinical experience, it is beneficial as she can teach students properly."

Private Institution

An SP participant described her current clinical teacher: "The present clinical teacher is skilful. She knows how to communicate with the patients. She can figure out the situation when students need guidance. She is always there for the students." Another discussed the value of clinical experience:

> Clinical experience is important for nursing faculty. It provides confidence to teach, it gives them the control to deal with the complex patients. I have seen that faculty members who have clinical experience are better in assessing the needs of patients and can find alternative measures to meet the needs of patients which are satisfying to them. They have good relationship with the health team members.

A third participant depicted her experience in a critical care area:

> Working in the critical area care is difficult for most of the students. Skills are complex; reading from the books is different than performing on the real patient. I can't forget my first experience in the cardiac ward when I was learning to measure the central venous pressure. Having "Barbara Bates" [a textbook used in nursing for physical assessment] in one hand trying to figure out, it was not until my teacher assisted me and taught me how to do it that I could really do it.

One SP participant believed that "nurses have to be skilful and knowledgeable; the physicians expect the nurses to know everything about their patients"; others suggested, "If nurses are to prove their value to society, they need to have good knowledge and skills"; and

> I believe if the teacher has worked in the ward, she has more confidence in the patient care and she is aware about the routines of the wards. For example, she would know that in ward A, the patients over [a term used to describe the nurses' report on the condition of patients in the wards] is done at the nursing station or at the patient bedside.

Another PS participant stated, "It is important to have scholarly knowledge and nursing skills." Sharing her views further she said:

> A couple of months ago, among friends we were discussing on this issue; if the clinical experience of a teacher has an influence on students learning. We felt yes, it has a great impact especially in enhancing students' confidence while caring for the patients. I am in Year III and soon I am going to graduate and become a qualified nurse. Soon, I will be assigned a unit and will be responsible for 15-20 patients to take care of them. I don't know how I am going to do it.

A PS participant lamented, "Knowledge and experience is important for a nurse. However, the rate of turnover of our faculty is so high; there is no consistency among teachers." One participant questioned:

> How would you define knowledge and experience? To me knowledge is that information which can be imparted to the students in a manner that is remembered and practiced in the practical life. The concept of experience to me in nursing is broad, experience comes with the practice but one needs to seek the opportunity to learn.

Another participant discussed the importance of knowledge and skills:

> Knowledge and experience go hand in hand. A nurse requires basic knowledge in order to perform skills. Without knowledge one can not provide rationales for an action but on the other hand one needs to know how to do it. Today nurses are expected to think and reason the care and that requires knowledge and skills.

Four participants agreed that a clinical teacher should have clinical experience but did not elaborate.

In summary, the participants from the government and private institutions strongly believed that a clinical teacher or nursing staff should have clinical experience because it enhances students' learning.

Teaching and Learning Strategies

Question 4: What teaching learning/strategies should a teacher use in the clinical area to facilitate student learning?

I used the word *should* in this question because, as stated earlier, in the government institutions clinical teaching is conducted by staff nurses instead of clinical teachers. It has also been my experience from working in a government hospital that an understanding of the concept of teaching and learning was limited in these settings, which prompted me to use *should* to explore the students' understanding of it. Because of the differences in clinical philosophy, government and private institutions use different teaching and learning strategies. The following section discusses the two types of institutions separately.

Government Institutions

Only five participants from the two institutions responded to this question; the rest had no comments to make. The following are the responses of those who volunteered information.

An SA participant reported, "We learn on our own. There is limited guidance given to us by staff and teachers." An SB participant explained, "We don't have teaching aids like overhead projectors. If we have any clinical issue to discuss, we ask our classroom teacher, and she helps us." An SB participant suggested an alternative strategy for learning: "The classroom teacher can assign patients on the ward. I don't know how to deal with patients having hepatitis and Down syndrome. The teacher can tell us to find more about such disease and can arrange a learning experience." Another SA participant talked about resources: "One needs to have resources to teach. We do not have a practice room to practice." An SB participant expressed her frustration: "Teachers must use recent teaching techniques; we are using the same lecture method as in the classroom."

Private Institution

The following are the responses of the 14 SP participants who responded to this question.

> There are different strategies used by our teacher to promote learning in the clinical area. We practice in the skill lab before going to the ward. We practice in the skills lab, until we are signed off. We are not allowed to perform a skill with patients until we are signed off. We even practice skills on each other. I cannot forget the experience of breast self-examination [BSE]. We were so shy to perform the BSE in front of the faculty, can you imagine performing the skill in front of the teacher. But we did it as we had no choice, now we are at ease to perform it with the patients.

> An Objective Structured Clinical Examination (OSCE) is used to test our skills. It should be continued to be used as assessment. I like the way it is structured, in which a student has to perform the given skills in a given condition within a given time duration. The oral medication administration station was well organized, for a second I thought I was in a real situation.

In the same context one participant said, "Discussions about patient care are beneficial for students' learning. One tends to think about reasons why particular symptoms are present in the patient and what should be done. I enjoy group discussion." Another participant mentioned, "I learn by discussing the patient's diagnosis in the clinical area." The participant who had expressed her views on case studies and presentation stated, "Case studies and presentations are helpful. I remember the case study presented on a patient with renal failure when I was working in urology. My teacher guided me, and I was able to present in the postconference."

Addressing the topic of pre- and postconference, an SP participant stated, "The conferences in which we share the nursing care are useful because then we can retain information shared in the group." Another participant agreed on their usefulness: "We have pre- and postconferences in which we discuss patient diseases in the group. It is helpful because we are able to relate the medication with the disease."

The participants saw being able to write NCPs as a critical skill for nurses:

> Initially, writing NCPs was difficult for me; I could not figure it out. Nursing diagnoses would never match the subjective and objective data, but my teacher sat with me and went through step by step, and now I can make a NCP. In fact, I am so good in writing NCPs that my friends ask me to help them out.

Another commented, "We share journal articles on the important topics which are recent, such as pain management in surgical patients."

A participant shared her experience of field visits:

> The field visit at Darul Sukoon [institute for the mentally handicapped people in Karachi] was an enlightening experience. One appreciates God's kindnesses which are granted to us after the visit. After the visit I enrolled to help special children in my area, and now we have a committee to support the well-being of these children.

One SP participant said, "Lots of strategies are used—presentation, case studies, and reflection—which expand students' learning." In the same context, another said, "There are lots of strategies one can use in teaching, but it depends upon the student how he/she wants to use that information." A participant reported, "We have grand rounds once a month where nurses from all unit present on a critical situation. I learn a lot from those presentations."

Another participant discussed clinical objectives: "Teaching and learning strategies depend upon the course. In community we have field visits to rural communities and go to water and sanitation plants, for example. The teaching and learning strategies depend on the course and its objectives." In response to this question on teaching and learning strategies, one participant preferred demonstrations: "I learn by observing a faculty demonstrating skills, and then I practice. We have one whole day for practicing the skills."

This section explored teaching and learning strategies that are used to facilitate students' learning in the clinical area. The government participants had few comments to make, but the private-institution participants suggested a number of strategies, such as reflection, NCPs, pre- and postconferences, case studies, nurses' grand rounds, discussion, demonstration, and presentation.

Written Assignments

Question 5: What are your comments on written assignments in clinical courses?

Four participants from the government institutions responded to this question, and 11 nodded their heads without providing a verbal response. The students from the government institutions were familiar only with NCPs, whereas the private-institution students were familiar with reflection, case studies, concept maps, and functional health patterns, as well as NCPs.

Government Institutions

An SB participant responded to the question on written assignments:

> We used to write nursing care plans in Year I. We are not doing it anymore, but I am doing it for my own learning. The usual practice is we would write a NCP in the ward. The classroom teacher would check it and give it to us in class. I would write a care plan on the patient and submit it to my teacher to be marked. It was interesting for me to note that she was not with me and did not observe me while I was assessing the patient but she would give me the feedback. Other than a NCP, we do not have any sort of written assignment.

Another SB participant replied, "We write nursing care plans, but I question the learning taking place by writing the NCP, the reason being, most of us copy from the book and give it to teacher; she uses the same book to check our work"; and another mentioned the difficulty of writing NCPs: "It is difficult to write nursing care plans based on the limited knowledge we have been given by our teachers." An SA participant explained, "We write NCPs, but there is no feedback provided to us on the areas to improve. Therefore our learning is incomplete without proper guidance."

Private Institution

A PS participant questioned the application of the NCP to patient care:

> In regard to the applicability of the NCP there is nothing, because, many students make pre-NCP. This means the students write a NCP before assessing the needs of the patients in the clinical area. The reason being the students have lots of burden with written work, they have to fill a functional health pattern [FHP] form, write a NCP and a teaching plan. Students make NCPs before hand as they have to submit it to the teacher on the same day as the clinical. To fill a FHP, one asks so many questions to the patients that it becomes irritating for them. The form should be short and brief. A few days back I was filling a FHP and the patient got anxious on the question dealing about the financial status. The patient got so irritated with the question that he said "Are you going to solve my financial problems, why are you asking? I explained to him that I am a student and filling out these forms is part of my learning process. At the same time the patient said, "If you are asking all these question for nothing, why ask?" Thus, I believe the FHP should be short and brief.

Another participant described the process:

> I write a nursing care plan for the patient I am assigned to. The faculty comes the next day, and I discuss the whole plan with her. She gives me feedback on the assessment and the interventions I have written for the patient. In this way I know what interventions I have to perform and why I am performing them. I learn by discussing. Initially, I used to spend eight hours writing care plans, but now I can write one in a short period of time. One thing which is difficult is providing the references for the scientific rationales; this takes lot of time.

An SP participant commented on concept mapping:

> We have to do concept mapping on one of the patients we select. I know I am learning a lot, but when I become the staff nurse, there is no concept mapping required in the ward; it is the practical skills which are needed.

Another participant described the benefits of concept mapping:

> Concept map [CM] develops the critical thinking skills. When I did a CM on a patient with myocardial infarction, I was able to relate the pathophysiology of the disease, medication, and lab work. I was able to do that with the support of my faculty member. She is knowledgeable and a critical thinker.

An SP participant provided food for thought:

> We adopt everything from the West, from the NCP, FHP, and now concept mapping. Have we seen the application to our culture? In anterior schools of nursing [those located in rural areas] student nurses do not even know the component of NCPs, but they are able to care for the patient.

A participant spoke about the workload: "We are given lot of written assignments in the clinical area. I can hardly focus on the patient care. I am all the time worried about finishing the NCP." One shared the frustration of disturbed sleep patterns on clinical days: "On the clinical days I sleep after 2:00 a.m. and wake up at 5:30 a.m. to reach clinical. How is a brain going to function? There is so much to read and write on clinical days."

With regard to the students' reflections being graded, one participant complained, "Reflections are graded in the clinical area. How can one be graded for personal feelings? Once we know that it is graded, we write what our teacher wants to read to get better marks." Another participant responded:

> Reflections are an important process for learning. I remember writing reflections on a patient who went into cardiac arrest. This was my first experience observing a patient getting CPR from the health team. I was observing nurses; one was bagging and another was giving intravenous medications. The whole picture is right in front of me when I am talking to you about the situation. I learned how important it is for a nurse to be skilful and at the same time being observant.

A participant commented on case studies: "We discuss case studies in the clinical area. We present the information from books and compare with the patient. In this way we learn and remember the disease process." Another saw the case study as "a great learning strategy. It helps me to relate a patient's disease and the care provided. In second year we had a case study on a patient with a mastectomy. I still remember it, the way it was presented."

Two participants agreed, as one put it, that "we have a lot to write in the clinical day such as a nursing care plan and a reflection. All the written work is expected to be ready on the next clinical day, which is too much." Four participants did not respond to the question.

This question explored students' understandings of written assignments in the clinical area. It is evident that the private-institution participants are familiar with various types of written assignments such as case studies, reflections, functional health patterns, and NCPs, whereas the government-institution participants are familiar with only NCPs. However, the participants suggested a need to incorporate other methods into teaching.

Pre- and Postconferences

Question 6: What are your comments on pre- and postconferences?

The participants from the private institution had had experience with conferences. They discussed the significance of pre- and postconferences for student learning and suggested that student- rather than rather than faculty-led conferences are useful. A critical point that emerged in the interviews was the duration of the conferences. The government participants had had limited exposure to conferences, and only two answered, as indicated below.

Government Institution

The two SB participants who responded to this question said, “We do not have the conferences. We go for clinical experience in the ward and work with staff nurses”; and “No, we don’t have any such things.”

Private Institution

A PS participant viewed pre- and postconferences as “helpful; we discuss a patient’s disease and the nursing interventions.” Another reported, “In postconference we present the situation and case studies which are important for practical exams.”

Another participant said, “We do presentations on the disease process after coming back from clinical. One is tired after a long working day.” One highlighted the importance of preconferences: “Preconferences are important as they are where we discuss our objectives. However, sometimes we spend so much time in discussing the planning that we miss the patient care in the ward.”

One participant explained that

> some of the postconferences are student led. Faculty facilitates the learning process, and those conferences are helpful. We do presentations in the conferences, but these presentations should not be graded. Once these presentations are marked, students become grade oriented, and learning is minimized.

With regard to the effect of conferences on students’ learning, a PS participant was discouraged that, because “every clinical group is different, having distinct learning needs, there is no consistency among faculty.” Another participant suggested a solution: “Students should be asked what they want to learn rather than dictated what to learn. Students know what is important for them.”

One of the participants discussed the significance of pre- and postconference in this way: "Pre- and postconferences are helpful. It is important to have conferences in year I as students have a number of things to share for which they need some guidance from the group."

Another PS participant expressed her concerns about the structure of the conferences: "There is no structure for pre- and postconferences. Sometimes time is wasted organizing the group together." Another "question[ed] the learning in the postconferences." One referred to the effective utilization of time: "If we have the postconference in the ward, that saves time. Booking a venue for conferences at the school is time consuming due to limited space."

Two participants had mixed feelings about pre- and postconferences, and they responded that they are "okay." When I asked what "okay" meant to them, they gave no explanation. However, one of the participants from the same institution elaborated, "Pre- and postconferences are useful when we discuss the nursing care of the patient. Clinical teachers need to organize conferences well. Most of the time is wasted on discussing what to present in conferences." One participant felt that "some teachers have too long conferences, which are boring and time wasting."

This question investigated the concept of pre- and postconferences and how the students saw the learning experience enhancing their clinical learning. In general, they perceived the conferences as useful in helping them to learn clinical concepts.

Clinical Evaluation

Question 7: What are your comments on clinical evaluation?

Clinical evaluations are stressful for nursing students. Both types of institutions use a pass/fail system; however, the process at each institution is different. In the government institutions the students are under staff supervision, and the staff inform the class teacher about the students' performance in the clinical area. However, it was unclear from the participants whether any format is used for evaluation. According to the students, evaluations are done verbally.

On the other hand, in the private institution the evaluations are based on five criteria: nursing process, communication, professional development, teaching/learning, and psychomotor skills. In addition, students are required to sign a form after they receive feedback for the summative evaluation. This indicates that students agree with the comments provided by the clinical teacher. This question is addressed in two sections: the responses from the students in the government institutions and those from the students in the private institution.

Government Institution

An SA participant explained the process of clinical evaluation: "After clinical the teacher asks us what we have done in the clinical and, based on that, gives us feedback. Our senior staff nurses inform our teacher on how we have performed in clinical." Another participant from the same institution stated, "Staff nurses assess us and notify our teacher about the performance. They don't have any evaluation tool. What they do is, when we are performing the skills, they supervise us and tell us verbally how we have performed." An SB participant shared her experience: "When our teacher is on rounds in the wards, staff nurses inform the teacher about our work." A second participant from the same institution said, "The teacher on her round checks the students and tells them about their mistakes," and another commented on the grading system: "We get the passing grade in clinical." An SB participant discussed the process of evaluation:

> We go on clinical and we work with staff nurses, they give feedback to the teacher on how we have carried out nursing skills in the wards. We know that our future is in the hands of staff nurses, thus we try to be good. Even if we want to ask anything we remain quiet. We do whatever they ask us to do in the ward.

Another SB participant voiced her concerns: "The staff should understand students and their levels of performance. In most situations the staff forgets the names of students. In such conditions, how do they know how we performed?"

An SA participant expressed her frustration with evaluation:

> If we disagree with the feedback given to us by the staff we keep quiet; there is no point in disagreeing with them. All the students are stressed that if they show disagreement with the staff the classroom teacher will take revenge. The revenge is failing the students and this would result in a student being six months behind in the nursing program.

Another participant from the same institution commented:

> Our teacher asks us what we have learned in clinical, so in this way she gives us feedback. She does not come to the clinical area but she will ask in class what we have practiced in the clinical area, and based on the conversation she will give feedback. To me this does not make sense when one has not even seen you performing the patient care and then evaluates your performance. In most situations, the students will tell a teacher things they have not even done for the patient. This is clinical practice.

An SA participant reported:

> Clinical is not graded. . . . However, by the end of three years we become expert in skills. In second year we are scheduled to work in the ward with one staff. This experience gives us opportunity to gain confidence in the clinical area.

An SB participant recommended, "We should be given ongoing feedback in clinical." A participant from SA argued, "The clinical is not graded. It should be graded, and there should be a policy that if student don't pass, they should do additional practice in the wards."

Three participants did not answer this question in spite of my two attempts to probe.

Private Institution

One PS participant described clinical evaluations as follows:

> Evaluations are painful, especially when it comes to clinical evaluations. Our clinical teachers are all the time with us in the clinical; they observes us utilizing the nursing process with patients. We are guided all the time, but it is stressful. We get ongoing feedback and a final evaluation at the end of the clinical rotation.

Three others explained, "We get the feedback on five components: nursing process, psychomotor skills, teaching and learning, communication, and professional development"; "Clinical is pass and fail. To pass we have to demonstrate the ability to perform nursing skills on the patients"; and "We get ongoing feedback on our clinical performance."

One participant advised, "The clinical teacher should see how hard the student is working to accomplish the clinical objectives, rather than focusing on how well a student can speak English." Another expressed her views on the evaluation process: "I received verbal feedback not on paper; my teacher told me I am performing well; she will give me more critical patients next time. She even said I am working hard and improving in writing NCPs."

Two participants suggested, "I think, the first semester of the nursing program should not be graded, because in this period students have anxiety about performing skills in clinical. The first six months should not be graded so that students can overcome their anxiety and can learn more"; and

> Clinical assignment should not be marked as students are always stressed out by evaluations. I believe past evaluations have an influence on the present clinical performance. Once I was told to work on the teaching plan, and still I get the same feedback. I wonder why.

One participant remarked, "We get comments on the clinical evaluation tools, which indicate how we have performed in the clinical"; and another said that "learning contracts are a part of clinical evaluation—stressful."

Another participant explained, "Objective Structured Clinical Examination (OSCE) is included in the clinical evaluation, and students have to pass it. It is great, but one has to perform different skills within the given time in the controlled situation." Four participants declined to respond for unexplained reasons.

It is evident from the students' comments that clinical evaluations are stressful no matter who performs them. In the private institution the evaluations have five components: nursing process, professional attitude, communication, teaching/learning, and psychomotor skills. It might be useful to explore the process with staff nurses and classroom teachers in the government institutions.

Stressors

Question 8: What are the stressors of a nursing student?

The participants from the private institution related their stressors to the clinical experience itself, evaluation, assignments, and self-evaluation. The government-institution participants indicated their frustration with having to live in residence, financial limitations, working on the ward, and the increased workload.

Government Institutions

An SB participant complained about the residence:

> I stay in the nursing residence. I have no relative in Karachi. I came from Lahore to do my nursing. The conditions in the residence are bad; there are four students sharing a small room. There is no proper ventilation in the rooms; in the summer when the temperature is high, it is difficult to study in such hot weather. Besides that, when one goes for a shower, there is often no water in the tap.

Another SB participant commented on the food provided at the residence: "We are tired of eating the same food [*chapatti* and *dal* every day]." An SA participant identified another stressor: "Being a nursing student, one needs to respect seniors (Year II and III nursing students). We are always under pressure!" A participant from the same institution discussed the financial status of students:

> There are sixty to seventy percent of students who are not financially strong. Students joined nursing because of money [stipend]. I am not financially sound; I have to support my family. Thus, I have to work part time in a doctors' clinic; it is difficult to take time for studies.

In regard to the limited material resources, an SB participant stated, "The demonstration room is small for our class to practice a skill."

An SB participant identified the shift work as a stressor:

> Yesterday I worked a night shift in emergency. I was the only female and was uncomfortable to work among male co-workers. Today when I went to share my concerns to the supervisor, she did not pay attention to it. In this situation, what is a student supposed to do?"

Another participant from the same institution commented with regard to the learning experience:

> We tend to perform the routine things many times, and we don't get a chance to learn new things, and sometimes senior staff does not help us to learn new things. This is because we have lots of patients, and the routine is giving medicines to the patients, changing their beds, and checking their vital signs."

An SA participant reported:

> When we have duty in the emergency ward, we have to look after the patients admitted and those who are still under observation. Sometimes we have only one staff member or sometimes nobody, so we have to look after each and every one.

One participant from the same institution cited duties as stressful, and when I asked her what she meant by *duties*, she explained, "Working on the ward with staff. They expect too much from the students to perform on the ward." Another SB participant said, "We get tired, as we have to look after all the patients."

The rest of the government participants did not respond to this question, and I did no further exploration.

Private Institution

A PS participant was concerned because

> going to the clinical area is stressful. In clinical the teacher is constantly observing students, and she is there to pick up on small mistakes. I am always worried about evaluation. Clinical evaluation is not pleasant. I find out about weaknesses during the evaluation, when it is too late to prove oneself.

A participant described her stress over evaluation:

> I feel sometimes the clinical teachers are biased on the marking. Last semester I worked on the paper for my rotation and my friend in the other group worked on a similar theme. I got an A and she got a C. The only reason mentioned by her faculty was that disease is not common. There is inconsistency among teachers.

Another student said, "Evaluations are stressful; my heartbeat goes fast when I am sitting in front of clinical teachers to receive feedback. I believe the word *evaluation* is terrifying. It should be changed to something else."

Personal safety was mentioned by one participant:

> Safety is another concern for me when I take care of male patients. I am afraid how they are going to react to the care given. I have to provide this care in front of my teacher; she is observing me. Most of the time I select female patients to avoid these problems.

Another participant contended, “Going to another facility for a clinical experience is hard. The difficulties are related to the lack of understanding of the nursing role.”

One of the participants identified assignments as a cause of stress:

> The biggest stressor for me is the number of assignments I write to pass the course. There are assignments every week. Sometimes there are two marked evaluations on the same day. Learning has to be enjoyed, but how you can enjoy your studies when you have tons of assignment.

Another participant described one of her stressors: “The major stress for me being a student is to meet the expectations of my faculty. I work hard to make sure I submit my assignments on time.” Another participant found that

> Being a student and managing family responsibility is not easy. Initially, my husband was not supportive of me becoming a nurse. It took some time for him to understand what I am doing. I used to wake up early to clean the house, cook, and get his things ready for the office. My mom took care of my daughter. It was stressful to manage married life and student responsibilities.

One participant shared the strategies that she uses to relieve stress: “We have a common room on each floor to rest. We can watch TV after 1700. To maintain a healthy mind, I go to the sports complex daily. There is a separate room for females to exercise.” Two participants found the clinical experience stressful, but they did not volunteer details.

This question explored the stressors that nursing students in the private and government sectors face during their educational period, and they discussed the various types of stress.

Culture

Question 9: Do you think culture has an influence on the nursing profession?

Most of the participants felt that culture has an impact on the nursing profession. The private-institution participants commented positively on the changes in the status of nursing in society.

Government Institutions

An SB participant said, "I don't discriminate against patients, whether it's male or female, but in this institution we are not allowed to take a history of male patients." A participant from the same institution stated:

> Every hospital has a different culture, depending upon the community; the community is its people. Islam teaches us to care for people but some limitations are seen in implementing the teachings of Islam. For example, when I was on the Pediatric ward there was a woman who had triplets; this was our first experience of triplets so we went to see the mom and newborn. During that period we were asking the mom about her experiences and she said, "Why do you want to know about me?" We tried to explain but she would not understand the reason for asking her. Later on when the doctor came for assessment, she said "I do not want you to touch my babies; you are going to do black magic on them." Thus, it is sometimes really difficult to deal with patients coming from different cultural backgrounds.

An SA participant explained:

> Young girls from interior Sindh are not allowed to join nursing because of its negative image. Initially, I had problems with my in-laws when they came to know that I was joining the nursing profession, but now they understand more about what nurses do.

An SB participant elaborated, "Before the Indo subcontinent partition, most of the nursing students belonged to Christianity. But we now have nursing students from all religious backgrounds." Another reported:

> When patients are admitted to the ward with a serious condition, their attendants bring Holy water to drink, *tawiz* to wear, and read the Holy book [Quran] at the patient's bedside. They believe that their patient can be cured with these traditional approaches. We have to respect their cultural beliefs and act accordingly. Last year during a home visit in one of the rural areas of Sindh, in one of the households while interviewing the grandmother, she said her daughter-in-law had delivered a baby boy, and it was their practice to isolate the mother in a room for forty days. On asking why this traditional practice was used, she said, "I was asked to respect this traditional belief. Women in our culture have been doing it from generation to generation, and we had no problems." At that time I was worried about the postnatal care, but I suppose God has its mechanism to take care of fellow human beings.

An SA participant described her experience with male patients: "I have difficulty with those males who do have rigid boundaries around them. They do not want to be given medications by a female nurse." An SB participant explained:

> Culture has influence on nursing. When working in the orthopedic ward once when a male patient wanted a urinal, the female attendant refused to give it to him because he was young. Then a male staff had to give the urinal. In the same way I think because nurses have to take care of males this profession is looked down upon.

Eight participants agreed that culture has an influence on the nursing profession. When I asked "How?" they did not elaborate.

Private Institution

A PS participant expressed her views on the nursing profession: "When people say negative things about the nursing profession, this is because their mind is negative. The profession is excellent; it's the way the profession is looked at and interpreted by the people." Another participant believed that "the image and status of nursing in the country is changing with education. The education referred to here is the nursing education, which has also brought awareness among the general public about the role of nurses." Another participant shared her views:

> People are becoming more aware about the nursing profession. Initially, no man wanted to marry a nurse, but now the men are looking for a nurse because they know she would be able to manage the family. The other reason being she would be able to bring additional income to the family.

A PS participant mentioned that nurses have greater opportunities: "Before, nurses had limited opportunities; now nurses have great job offers from other countries. Recently, there were recruiters from the United Kingdom who came here, so nurses are in demand."

Another participant said, "Culture has an influence on nursing, but it is upon individuals how to practice those teachings. One of the examples which is important is to respect an individual regardless of their sex."

One participant spoke of the initiative that the government has taken: "The government is taking positive steps in Baluchistan to recruit nurses from their region and uplift the image of nurses." One student said, "We now have married women coming into nursing; this is a big change"; and another added, "Males are now enrolling in nursing. Thus people are starting to accept them."

One participant explained:

> Cultural values and traditional beliefs are transmitted from one generation to another. Islam teaches us to respect a person who requires care or assistance because he/she is unable to care for himself or herself with dignity. I believe nurses have a lot of responsibilities in society. The way a nurse talks has to be professional. I have seen some nurses wearing tight uniforms, not properly ironed and having make-up as if they are going to a party. In such situation, no one is going to respect a nurse and the nursing profession.

Three participants agreed that people's attitudes are changing, but they did not discuss to how or whether it is for the good or bad. Three did not have any comments.

This question explored the understandings of the participants in relation to how culture has an influence on nursing practice. These students believed culture has an impact on the way nursing is seen in Pakistan. They offered a variety of examples and vividly described their understanding of this issue.

Clinical Teaching in Pakistan

Question 10: How would you like to see clinical teaching in Pakistan?

This question sought the student participants' perspectives on clinical teaching. Again, I have group the responses according to the type of institution.

Government Institutions

An SB participant recognized the shortage of nursing staff:

> Every student should get individual attention in the clinical area so that we can get good feedback. Because of the shortage of nursing teachers, they have a lot of burden on them, they have to look after so many students. They can't give proper attention. What should be done is one clinical teacher should get twenty students, not more than that, so she can give proper attention to the students, and in this way students would be more satisfied.

Another participant from the same institution suggested, "We need clinical teachers first"; and an SA participant expressed her concerns:

> I would like to see congruency in what we are being taught and what is implemented in the ward. Just a simple example is in taking vital signs; in the tray we are taught to keep two bottles, one with soapy water and another with plain water and bowl of cotton. In reality what is practiced is different. We just have a thermometer in a disinfectant, no tray. In fact one cannot find a tray in the ward because they are locked in the cupboard. We have to take the temperature of fifty patients' within half an hour. How is it possible to follow the correct procedure? Therefore, what we learn in books is not performed in practice. Another example is that nursing students are told to write nursing care plans, but if there is no follow up on them, what is the use of writing nursing care plans.

Another SA participant advised, "Nursing students need to be monitored and guided in the clinical area." An SP participant had remarked that "students are in the learning phase, and it is important they get guidance at each step," and an SA participant shared her view:

> If something wrong happens and nursing staff members make even small mistakes, they are fired but at the same time if doctors do a blunder nobody takes action on it, not even the medical director of the hospital. In these circumstances nursing staff are fearful to provide us with opportunities to practice new skills. There is no one whom we can talk with; I don't know why health care highlight the small mistakes we do while big error made by physicians are not even mentioned. I suppose this is because the management feels that if they mention the name of the doctor the reputation of the hospital is in danger.

An SB participant suggested that there is a need for more public health units:

> The population of Pakistan is growing day by day and we have to teach people about family planning. In addition, there should be units public health in villages because when patients are traveling from far away areas they sometime die on the way without having received any medical assistance. Doctors and nurses should go to villages to help people who need help to keep themselves healthy.

Another participant from the same institution said, "There should be no night shift for females. During the night there is only one female nurse among three males. In this situation there should be more than one female nurse for safety reasons." An SA participant proposed, "I think we need a separate clinical teacher in the clinical. The staff nurses are too busy with their routine work."

Another participant from the same institution questioned, "Nursing is about skills; without knowledge how you can expect a nurse to provide care which is based on sound judgment? Being a student in a government institution, we need teachers who have knowledge of recent nursing practices." The other participants did not have any comment on this comment.

Private Institution

An SP participant said:

> I have no problems with the present teaching practice. The clinical teacher comes in the clinical areas and guides individual students based on the learning plans. The teachers demonstrate the skills before we practice in the clinical area. We get ongoing feedback on the performance using a standard format.

Two participants from the same institution stressed, "We need more nursing teachers who can understand students' learning needs," and "Clinical teaching in Pakistan can be successful if we have resources. These resources are human and financial."

A participant shared her views on clinical teaching in Pakistan: "Clinical teaching is complex. I believe in order to respond to this question, there are multiple factors which influence clinical learning. The major one is the collaboration between education and service." Another suggested, "I believe if clinical teaching in Pakistan is to be better implemented, we need to have teachers in the government sector who are willing to be in that role." One simply said, "Clinical teaching in Pakistan, one needs to think about it." Five other participants from the private sector agreed that it is a complex process, and they needed time to reflect on it. Three participants did not comment even after I asked them the question a second time.

This question sought the general views of the participants on how they would like to see clinical teaching in Pakistan. It is evident from the analysis that students from the government institutions need guidance and support in the clinical area. In addition, it is critical to protect student nurses on night shift. The students in the private institution highlighted the relationship between education and service for effective clinical learning.

This chapter presented the data on the 10 questions that I asked nursing students at the three institutions. Some students were able to provide elaborate answers, whereas others had limited comments to offer. This issue is further addressed in Chapter Six, the discussion chapter.

CHAPTER SIX:

DISCUSSION

The purpose of this chapter, which is divided into two sections, is to discuss the findings presented in Chapters Four and Five. In the first part, the responses of the nursing faculty members and nursing students to six research questions on clinical teaching practices in Pakistan are discussed. I asked nursing faculty members 16 questions and nursing students 10 questions to collect data for the study. The reason I chose to ask the nursing students 10 questions rather than 16 was that some of the faculty members' questions were not relevant for the students. I also kept in mind the students' comfort level with the research process. Literature is integrated into the discussion; however, it is important to reflect on the relevancy of Western literature to the Eastern community. In the second section, the recommendations based on the findings of this study are presented and the need for further research is addressed.

In general, the participants from the government institutions gave more limited responses to the questions than did the participants from the private institution because they may have been somewhat insecure or afraid of giving wrong answers and were concerned about the possible consequences for their jobs. Even though I assured them on the consent forms that I would maintain their confidentiality, the nature of their work probably played a role in this, and they may have been afraid that the information that they shared in their interviews would be exploited. It may also have been associated with their limited exposure to the research process.

With regard to language, most of the interviews in the private sector were in English, and the government respondents' preference was Urdu. I do not believe that this affected the results of the study as I am fluent in both languages. The intent of the study was to collect information on the topic regardless of the language. Thus, I gave the participants the option of conducting the interviews in either Urdu or English. Even though most of the students from the government institutions preferred to respond in Urdu, only one from the private institution answered in Urdu.

During the analysis it became evident that the numbers of years of classroom teaching experience did not appear to have a positive impact on the students' clinical learning at the government institution. However, the participants from the private institution had mixed feelings. Zoya explained:

> For me experience is not the only indicator. It is important, but not the only indicator. If a faculty has ten years of experience, but if students feel uncomfortable to discuss their problem with her, to me those ten years of experience are not worth it.

On the other hand, Susan rationalized, "Experience does not come overnight. Regardless of how knowledgeable you are, experience gives you skills to function at all levels." The students saw a faculty member's higher education as encouraging because it enabled the faculty member to adopt more flexible roles in teaching and learning. Bina contended that "education brings changes in one's approach toward teaching and learning. After enrolling in a master's program, I have been working with students in meeting their clinical objectives. We both are working together with each other."

The age of the nursing faculty members was not seen as making a significant contribution towards students' clinical learning. This led me to reflect on the notion of age and experience: What is the role of experience? The answer to this question is complex. An individual develops with the exposure that he/she has encountered during the course of life. It is difficult to comment on the impact of these variables on students' learning as this is qualitative study.

In the following section I explore the responses of the faculty members and nursing students to the six research questions:

1. What is the nature of clinical teaching in Pakistan?
2. What are the characteristics of effective clinical teachers in Pakistan?
3. What facilitates clinical teaching in Pakistan?
4. What are the practical challenges in clinical teaching in Pakistan?
5. What are the cultural barriers to clinical teaching in Pakistan?
6. What are students' views on clinical teaching in Pakistan?

Research Question 1

I purposely asked the broad question "What is the nature of clinical teaching in Pakistan?" to gather in-depth information on clinical teaching in Pakistan. This section included six questions that were based on the models of clinical teaching, the theory-practice gap, teaching and learning strategies, written assignments, pre- and post-conferences, and clinical evaluations.

The government-institution faculty presented their views on clinical teaching, and most highlighted its importance in Pakistan. Staff nurses in the government institutions do the clinical teaching. According to Karadag and Addis (2003), who explored the role of staff nurses in enhancing students' learning in the clinical area in Turkey, staff nurses helped students to adjust to the clinical environment. The role of classroom teachers was to conduct ward rounds that were not scheduled. What this meant was that classroom teachers would come to the ward during their breaks. These rounds were conducted based on the convenience of the teacher, and the visits could range from 5 to 30 minutes depending on the individual teacher. There was no expectation that classroom teachers would visit students on the wards. As a result, teachers play a limited part played in enhancing students' learning in the clinical area.

The findings from my study reflect the work of Karadag and Addis (2003). The participants from 13 government institutions identified the need for clinical teachers in the practice area and the limited opportunities for contact with students in the clinical area.

The private-institution faculty members were aware of the role of a clinical teacher in the clinical area and its implications for students' practical learning. As Dunn et al. (1995) indicated, it is in the clinical area where students relate theory to practice, learn necessary technical and interpersonal skills, and make clinical judgments. Benor and Leviyof (1997) recognized the clinical area as a crucial component of professional nursing education. A total of 18 participants in this present study indicated that clinical teaching is a process in which nursing students apply the knowledge that they learn in the classroom to the practice area. The participants had an understanding of the topic, but the problem was the integration and implementation of the concepts in the practical situation.

Thirteen private-institution and six government-institution participants described teaching in clinical as not simple, regardless of whether a clinical teacher or staffs do the teaching. The participants from both private and government institutions elaborated on the complexity of clinical teaching. They saw a number of factors contributing to complexity in the clinical area. Uncertainty of the patient's condition was nursing teachers' most common concern because they need to be prepared to guide students through challenging learning experiences while at the same time ensuring students' and patients' safety. The complexity of the learning experience increases if resources are limited and large numbers of students require ongoing guidance in patient care. Nine nursing students also recognized this concern. According to White and Ewan (1991), the complexity of the clinical environment increases the richness of the learning. The participants from the private institution restated what Reilly and Oermann (1992) noted: that clinical teaching is experimental learning in which students step into the experience to acquire knowledge and skills.

I also explored the concept of the theory-practice gap. Nahas (2000) argued that the discrepancy between what is taught in the classroom and what is practiced in the clinical area occurs because nurse teachers have been removed from the clinical area. The participants suggested that one way to reduce the theory-practice gap is to make the classroom teacher responsible for students' clinical experiences. Since the teacher is aware of the learning objectives it could facilitate learning in the clinical setting more effectively.

The nursing students commented that clinical teaching involves implementing the content and/or skills learned in the classroom in the clinical area, whereas the government-institution participants noted the difficulty of implementing knowledge into practice. One of the factors that they mentioned was the lack of guidance and facilitation in the clinical area. Routine practice makes staff nurses accountable for students' learning in the clinical area, and the reality is that one or two staff nurses in the ward are responsible for 50 patients, with no additional staff. A nurse is expected to do her routine nursing work as well as her clerical work, which includes maintaining an inventory of the linens and supplies in the ward, which makes it difficult for nursing students to receive guidance from the staff because of the nurses' lack of time. Eight nursing students mentioned limited resources for learning, including the lack of learning aids.

A student from the private institution showed a broad understanding of clinical teaching by providing an example of learning how to do tracheotomy suctioning. In Lyth's (2000) study, nursing students agreed with nursing faculty that clinical learning is complex. According to Reilly and Oermann (1992), 21 students expressed concerns about performing their skills on patients in an unpredictable situation. Tanner (1998) stated that in her 25 years of experience as a nurse educator, issues surrounding clinical teaching have persistently been identified in the literature and in practice. This is true for Pakistan; however, the problem is that limited research has been conducted on the topic. Clinical teaching is a formal process in professional learning, and nursing students require guidance from clinical teachers to achieve a professional level.

Models of Clinical Teaching

To understand clinical teaching, it is important to explore the approaches to it. The participants from the private institution discussed the Trio approach or the preceptorship model, in which the student, teacher, and staff are involved in the students' learning process. In Canada preceptors have primarily been used with senior nursing students and graduates to prepare for advanced-practice roles (Myrick, 1991). The participants from the private institution in Pakistan had been given theoretical information about the Trio model, but their practical knowledge of the process was limited. The Trio model was implemented in Year 3 in one of the practical courses only. The participants from the private institution initially considered the readiness of the staff nurses. They identified the need to overcome the problems that Karadag and Addis (2003) found in which staff nurses are overloaded with work and have difficulty enhancing students' learning on the ward.

The participants from the private institution emphasized that, in considering the preceptorship model, it is important that the preceptors who are selected have the desire to teach and the willingness to serve as a preceptor (Bain, 1996; Myrick, 1998a). Thus, I feel that some planning is required to consider cultural differences before implementing this approach. I found it valuable to attend Dr. Florence Myrick's preceptorship workshops at the University of Alberta because they provided insight into the process.

In the private institution a clinical teacher model has been the norm. In this model the academic faculty members are responsible for facilitating the clinical learning of the nursing students (Nehls et al., 1997). The positive aspect of this model is that academic faculty members do not take on patient assignments, which allows instructors more time to spend with students. However, one drawback is that, because they are not involved in direct patient care, they may lack practical skills. The participants in the present study did not voice lack of practical skills, as the majority had acquired clinical experience working in the wards.

In the government institution the staff nurses supervise the nursing students in the clinical areas. This learning process includes a staff nurse, students, and a classroom teacher. This process of teaching and learning is suggestive of the preceptorship model. However, the role of the classroom teacher was seen to be limited and therefore not truly a preceptorship model.

The institutions have different approaches to enhancing student learning in the clinical areas, but none of them have been evaluated to verify their effectiveness. The participants from the private institution were exploring different clinical models to adopt that would meet the clinical needs of students. The struggle to improve nursing education is evident, but it will require time and effort.

Teaching and Learning Strategies

In order to answer my first research question I explored with the participants on teaching and learning strategies that the clinical teachers at the private and government institutions were using. The private sector uses various teaching strategies such as case studies, research articles, journal writing, and reflection. Four participants mentioned innovation in teaching, which was interesting. This demonstrated the philosophy of educators in adapting to change according to the needs of society. All participants (nursing teachers and students) identified demonstration as one of the strategies employed to teach practical skills (Girot, 1993; Hartley, 1994; Hermann, 1997). Discussion was another common method that 19 participants mentioned (11 private-institution and 8 government-institution participants). The nursing process was also discussed. It would have been useful to further talk about how the nursing process is taught to develop students' abilities to think systematically.

The participants from the private institution mentioned the buddy system, in which two students from the same year are designated to work on the given assignment (Oermann, 1998). This learning process has its own advantages and disadvantages in student learning. One of the participants talked about the difficulty of identifying slow learners at the right time because of the complex nature of the clinical area. Second, the large number of students who must be supervised in the clinical area makes it difficult for a teacher to thoroughly assess their performance and identify slow learners.

Twelve private-institution participants discussed pre- and post conference as a teaching and learning strategy and identified three aspects: the format, structure, and duration of the conferences. Two participants from the government institution referred to the conferences, but not in detail. The private-institution participants use various teaching and learning strategies to facilitate students' learning, as suggested in the literature. For example case studies, presentations, reflections and role play.

The students in the government institutions learned most of their nursing skills by observing the staff. However, this may not be the right approach to learning because rationale was not provided for nursing actions. The other factor to consider in selecting a teaching and learning strategy is the availability of resources, and this was identified as a problem in the government hospital. The students from the private institution had a broad understanding of the learning strategies used in the clinical area. They mentioned demonstration; case studies; presentation; reflection; nursing care plans; field visits; and objective, structured clinical examinations. The importance of effective teaching skills in nursing education cannot be ignored (Brown, 1999; Infante, 1981; Wink, 1995).

The nursing students contended that teachers need to be selective and creative in using strategies and need to reflect on the content. A student from the private institution made the critical comment that teaching and learning strategies need to reflect the course objectives. To me, this is an important comment that integrates the implementation of the curriculum (Tanner, 1994). It would be significant to receive clinical teachers' input on the above comment.

I also explored the concept of written assignments with the participants. In the government institutions the use of written assignments was found to be limited, and only two participants elaborated on the topic. However, the private-institution participants provided detailed information and views. Eight participants commented that written assignments help them to evaluate students' performance; on the other hand, four thought that it is a waste of time because students become too busy with written work such as their nursing care plans (NCPs) to concentrate on patient care. The participants suggested that written assignments be used, but also that the number and the types of assessments be considered, this corroborates the views of Dillard and Laidig (1998), Roentree (1987), and Wilkinson (1999) who recommended having a realistic number of assignments to avoid putting too much stress on students.

A participant from the private institution viewed concept mapping as an effective approach to developing critical thinking among nursing students. It was interesting to compare the differences between the private and government institutions. In the government institutions the concept of NCPs hardly exists compared to in the private institution, where complex teaching approaches such as concept mapping are used. Twelve participants from the private institution saw written assignments as increasing the workload. Time is needed to mark assignments and provide feedback to students within a given timeframe. For the same reason, Smith (1977) examined credit allocation for clinical work and planning assignments according to the number of credits for the course.

I also investigated the concept of pre- and post-conferences in this question. A participant from the private institution offered an opinion on the purposes of conferences: "To provide an opportunity to share learning needs and to offer students direction in planning care". In addition, conferences were seen as tying together students' learning experiences. Role play as a teaching strategy is included in post-conferences to teach sensitive topics. In the government institutions, pre- and post-conferences are not included in the clinical experience because nursing students are assigned to staff nurses for the duration of their clinical experience. Staff nurses have their patient assignment and also have to supervise students.

Two government institutions' students indicated their limited knowledge and shared their views on the subject. Twelve private institution students related their experiences with pre- and post-conferences. One student said, "Conferences are helpful for students. It gives directions to the students to plan their clinical day." Another suggested, "Post conferences are to tie up all the experiences together." Thus, different views were expressed in response to this question. A private-institution student commented that the way that conferences are conducted depends on the clinical teacher. What this student meant is that some conferences are structured but others are disorganized, depending upon the teacher.

Clinical Evaluation

With regard to the participants' understanding of clinical evaluations, it was evident that they are stressful (Bondy, 1984; Higgins & Oscher, 1989). The process of evaluation in the government institutions is unclear because staff nurses do the clinical teaching and verbally evaluate the students without any prescribed format. The answer to this question appears to be inconclusive without the input of government staff nurses, who are key players in students' learning in the clinical area.

The private sector uses a standard format with five components: communication, professionalism, nursing and scientific process, teaching/learning, and psychomotor skills. It was revealed that evaluations are influenced by the teacher's experience and understanding of evaluation. Three of the novice faculty in the study expressed uneasiness with the process (Krumme, 1975; Quinn, 1995). The participants highlighted the significance of timely feedback and the need for objectivity, but because of the increased workload and the student-faculty ratio, the faculty were concerned about completing the documentation on time (Malek, 1988). All nursing faculty members in the private institution saw the evaluation process as one of their major stressors.

Grading nursing students on their clinical practice is one of the most challenging aspects of clinical teaching. Two of the nursing faculty members suggested that the clinical experience should be graded because if it is students come prepared for the clinical work and their performance improves. Other faculty members favored the pass/fail approach, which recognizes the complexity of grading (Whitney & Boley, 2003).

In exploring the concept of evaluation, I asked a number of questions. For example, when does learning stop and evaluation begin? Who determines the readiness for evaluation, the clinical teacher or the nursing student? For example, if a nursing student in his/her first experience forgets to check the identification band of the patient before administrating the medication, a clinical teacher may fail the nursing student for not meeting the critical component of safety and label the student as incompetent; or the clinical teacher may give the student another opportunity to redemonstrate the procedure.

Decisions are influenced by the clinical teacher's knowledge of the standard and skills in practice.

Malek (1988) revealed that clinical evaluation is one of the major stressors for nursing students, and the current study confirmed this finding. Oermann and Gaberson (1998) found that clinical evaluations cause strain on nursing faculty as well on nursing students, and the government students mentioned the anxiety of evaluation even though it is verbal. Most of the nursing students did not ask questions of the nursing staff because they were the evaluators. Studies on clinical evaluations that Caldwell and Tenofsky (1996), Girot, (1993), Krisman-Scott et al. (1998), Morgan and Irby (1978), and Oermann and Gaberson conducted confirm the findings of this study.

Questions used to answer Research Question 1 identified the participants' understanding of clinical teaching in Pakistan. Despite their limited knowledge of the role of the clinical teacher, the participants from the government institution responded fully. Both government and private participants stressed the need for separate clinical teachers. The other suggestions related to the need to strengthen collaboration between service and education, the importance of providing teaching resources to enhance students' learning, and the inclusion of clinical evaluation in the continuing-education session to ease faculty members' anxiety.

To summarize, the participants identified three broad areas in clinical teaching that require immediate attention: (a) the need for clinical teachers to have a teaching philosophy based on the values and beliefs that guide their teaching practices; they must also be knowledgeable and skillful in the subject area; (b) the need for teaching strategies to include a description of the written assignments and of the grading system; and (c) the need for clinical evaluation. Figure 1 depicts the concept of clinical teaching in Pakistan.

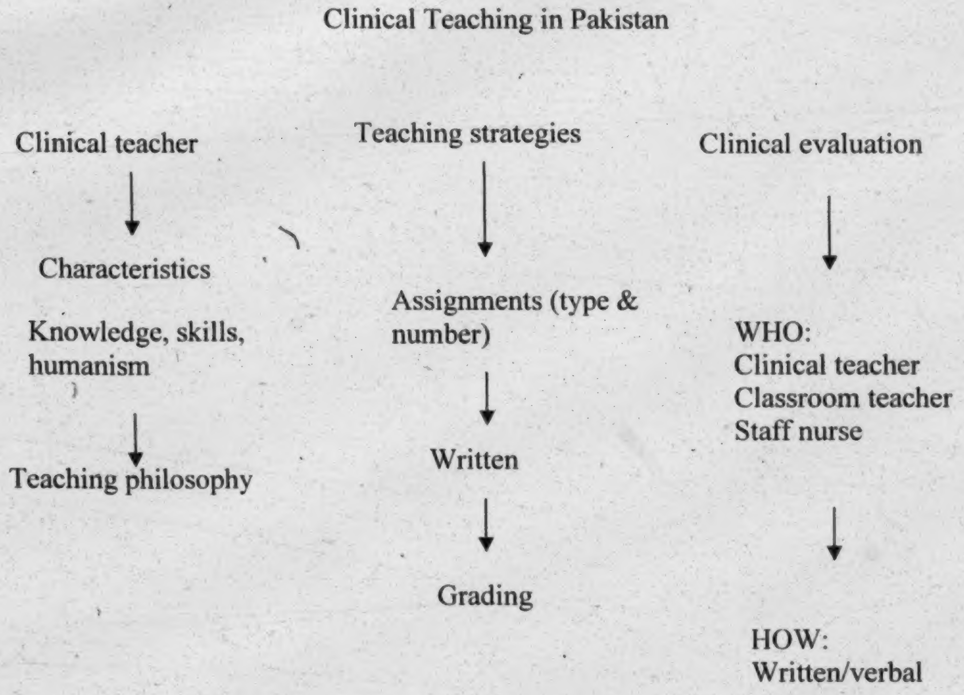
Clinical Teaching in Pakistan
Clinical teacher
Teaching strategies
Clinical evaluation
Characteristics
Knowledge, skills, humanism
Teaching philosophy
Assignments (type & number)
Written
Grading
WHO:
Clinical teacher
Classroom teacher
Staff nurse
HOW:
Written/verbal

Figure 1. The concept of clinical teaching in Pakistan.

Research Question 2

Research Question 2 asked, "What are the characteristics of effective clinical teachers in Pakistan?" According to Crotty (1993), the roles of clinical teachers are diverse. Students in Crotty's study saw clinical teachers as individuals who can promote or discourage learning in the clinical area. Hence, it was important that I explore the characteristics of clinical teachers. A student supported Irby's (1994) definition of effective clinical teachers with the comment that a teacher is one who possesses a good knowledge base, but can also transfer his/her knowledge to students.

The students from both institutions saw knowledge and skills as important characteristics of clinical teachers, and these views were supported by Benner (1984), Christy (1980), and Clifford (1993). The case was different with the government institutions students, who related these characteristics to staff nurses. In government institutions the students' learning in the clinical area is handled by staff nurses, and classroom teachers have limited input into the process. Thus, they are not directly involved in clinical teaching. It was therefore difficult to understand how these characteristics were seen in the staff nurses. The government participants emphasized in the interview that a clinical teacher needs to be knowledgeable, experienced, and competent. Clinical teachers in this context were referred to the staff nurses.

The participants from the private institution talked about the significance of students' internal motivation in learning. Fifteen participants repeatedly mentioned role modeling as a critical factor in students' learning. For example, Razia stated, "Role modeling is another attribute which I feel is important, because students look at you as superior to them, so you have to prove yourself by demonstrating professionalism." Similarly, Hamida asserted, "The important feature in clinical teaching is role modeling." The participants saw the role of a clinical teacher as promoting self-directed learning, which was exciting. Three private-institution participants mentioned self-directed learning. This approach encourages the concept of critical thinking, which nurses are required to develop because the curriculum cannot contain all of the content and skills that students need to know to become competent nurses.

A private-institution participant commented that "a teacher is a born teacher." One could debate this comment based on the existing literature and the education program, which is geared to preparing a teacher by imparting knowledge. It would be interesting to collect information on how other disciplines interpret this observation. In addition, with Benner's (1984) work *From Novice to Expert* in mind, it would be interesting to reflect on how these principles fit in Pakistani culture.

According to Benner et al. (1996):

> The practice of the expert . . . is characterized by engaged practical reasoning, which relies on mature and practiced understanding, a perceptual grasp of distinctions and commonalties in particular situation, . . . and increased intuition links between seeing the salient issues in a situation and ways of responding to them. . . . With expertise comes fluid, almost seamless performance. (p. 143)

There is no doubt that a teacher needs to have the ability to transmit information or knowledge in such a manner that each student can internalize it. It is notable that only one participant commented on "born teachers," whereas others did not did mention it. One of the reasons might be that teaching is seen as a traditional profession in society that is linked with the transmission of knowledge. It is important to research whether these skills can be learned or are inherent in a teacher.

Research Question 3

Question 3, "What facilitates clinical teaching in Pakistan?" considered clinical teachers' philosophy of teaching and learning and their comfort level with the concept of teachers' knowledge and skills in the clinical area. I also explored the concept of continuing education with this question. Even though it is not directly related to the research question, it indirectly helped to identify the learning needs of the participants, who saw education as a continuous process that starts from birth and continues to death.

During the process of growth one continues to learn from various sources to understand self and others. A participant identified the importance of learning from students' feedback. I felt that this comment is revolutionary because in Pakistan most of the nursing schools are still operating in a traditional manner, and hearing this statement from a nursing faculty member was exceptional.

Even though according to the participants the term *philosophy* is not understood, they discussed ideas such as respecting learners' values, appreciating individual differences, providing ongoing encouragement, being lifelong learners, and providing a conducive learning environment.

The participants considered the comfort level of the clinical teacher in the clinical area to be important because it has an impact on students' learning. In Paterson's (1997) study nine clinical teachers described the feeling of being "strangers" in the clinical area. In this phenomenon the clinical teacher and nursing students are not part of the system of care; they represent, according to Paterson, a temporary system within the permanent culture of the clinical setting. Therefore, the clinical teacher and nursing students considered themselves as strangers.

This question was irrelevant for the participants of the government institutions, where the staff nurses are responsible for the clinical learning/teaching of the students in the clinical area. Four participants from the private institution identified the struggle to be accepted in the clinical environment. However, it is evident from the data and the literature that if the clinical teacher has worked in that area, it increases his/her acceptance into the system, which is essential to ensure students' learning. Faculty members used different strategies to gain the trust of staff members in the ward, and this is true as well in developed countries.

In the government institutions the students are assigned to staff nurses, who are expected to have clinical experience, which solves the issue of comfort level (Benor & Leviyof, 1997; Bergman & Gaitskill, 1990; Nehring, 1990). Nine students responded that it is important for clinical teachers/staff to have clinical experience because it has a positive effect on students' learning in the clinical area, and the participants felt that most nurses possess the practical skills but lack skills in facilitating and providing rationale for their nursing practice. The findings of Fitzpatrick (2001) and Meleca et al. (1981) were similar. The experience of nursing staff was seen as facilitating students' learning in the areas of assessment and planning the care of patients. One of the participants suggested, "Experiences teach you a lot." It would be interesting to study the time required for a clinical teacher to become "experienced" and how one would know whether a clinical teacher is now an expert.

In response to the question on continuing education, the major focus of the participants from the private institution was on providing competent care to patients in high-technology situations. Competent care requires that knowledge and skills be integrated into the care. The government participants also stressed the need to learn how to provide care to patients in critical situations. They also discussed the need to focus on different aspects of the process of evaluation and the need for writing anecdotal notes. Nurses in Pakistan are in the infancy stage of their professional growth, and their needs for continuing education depends on the situation and the time.

Research Question 4

The focus of the Research Question 4 "What are the practical challenges in clinical teaching in Pakistan?" was on identifying the practical challenges in clinical teaching with regard to clinical placement and the different stressors that the participants have experienced in nursing. In the government institutions the nursing students have an in-house clinical experience, which means that they go to their own hospitals to gain their experience. Eleven participants felt that going to other organizations provided them with a variety of experiences that broadened their learning. However, the government institutions' participants identified transportation as one of the barriers to attending other facilities to gain experience. In the private institution the clinical coordinator arranges the clinical placements. Placements are selected based on the clinical objectives of the courses, as De Young (1990) recommended.

Clinical placements are essential to enhance practical experience. McCabe (1985) and Reilly and Oermann (1985) recognized the significance of the clinical placement in their studies. Several researchers (e.g., Benor & Leviyof, 1997; Nehring, 1990) conducted studies to evaluate the effectiveness of clinical placements. However, the availability of a clinical placement does not ensure the effectiveness of learning in the clinical area. Clinical learning is a complex process that encompasses a number of factors.

It was interesting to compare the stressors of the government participants with those of the private-sector participants. All of the participants from the private institution identified clinical evaluation as their major stressor in the clinical area. The data matched the study results of Oermann (1998), which indicated the factors of limited time in the clinical area, the number of students, and the acuity of the patients. All of the participants from the government sector mentioned the lack of resources. Six participants from the private institution reported increased workload related to marking written assignments. Seven participants from both institutions named gender issues as stressors. Anisa lamented, "Being a female and coming early in the morning to work is trouble." What she meant is that she had to prepare breakfast for her family and husband before leaving for work, which required getting up at 5:00 a.m. Another participant found balancing work and home life difficult. Nursing has always had a conflicted perception in our culture that reflects ambivalence in the meaning of womanhood. Davies (1995) explained, "Both the nurse and the work of nursing are firmly associated in the public mind with the female sex" (p. 2). This perception is still held in most countries of the world, but it is prevalent in Pakistani culture. Resolving the issues of gender and power in nursing requires that nurses critique and challenge these social misconceptions (Kalisch & Kalisch, 1987). It would be significant to study how nurses in developed countries have struggled to maintain a balance between work and home life.

Both groups of students identified different types of stressors. Carlson et al. (2003) found that students experience uncertainty in the clinical area because of the lack of learning opportunities to develop competence. This was the situation for the private institution students, but not for those in the government institution. According to the students in the private institution, the fear of making mistakes in the clinical area is a major stressor (Oermann, 1998). In addition, they worried that the clinical teacher would record anything that they did wrong on the evaluation form and that these comments would be passed from one teacher to another; whereas the government students had issues with accommodation and working conditions on the wards.

It was evident that the private-institution participants' stressors were much more academic. It would be interesting to explore whether these factors have an impact on students' learning. One participant from the private institution found "going to clinical . . . stressful." It is evident that the life of nursing students is stressful and that this is a universal truth. The stressors may be different depending upon the type of institution and the number of others factors such as interpersonal relationships and the style of instruction.

Research Question 5

Through Research Question 5, "What are the cultural barriers to clinical teaching in Pakistan?" I investigated the impact of culture on the nursing profession and the prevailing traditional and cultural beliefs in Pakistan. The data that I collected confirmed that the role of culture is significant in health care decisions. The participants from the private program made encouraging comments that indicated the general public's increasing awareness of the profession of nursing. A participant from the private institution was optimistic because "the image and status of nursing in the country is changing with education. The education referred to here is the nursing education, which has also brought awareness among the general public about the role of nurses."

The participants from the government institutions made negative comments about how nursing has influenced their personal lives. One of the participants reported:

> Culture has an influence on nursing. When working in the orthopedic ward once, when a male patient wanted a urinal, the female attendant refused to give it to him because he was young. Then a male staff had to give him the urinal. In the same

> way I think, because nurses have to take care of males, this profession is looked down upon.

This could be very much related to the hospital environment where the government institutions' students receive their clinical experience, which still operates in a traditional manner whereby women have not been given equal status, and male dominancy is evident.

These traditional beliefs have restricted the enrolment of females from rural areas in the nursing profession. The struggle for recognition in the developed countries is evident throughout history, and it has taken time and courage for nursing leaders to create a platform (the International Council for Nurses) where nurses can share their concerns. Nurses in Pakistan are working hard for recognition and status, and I believe that nurses will soon have the same status as physicians and lawyers.

The effects of gender on nursing have been part of nursing practice since its inception, but limited studies have been conducted on the effects of gender and power in Pakistan. The two male participants in the study provided an opportunity to explore their views about being male in a traditionally female profession. Mohammed shared his views about males in nursing:

> I think nowadays the perspective of having men in nursing is changing. In the professions which used to give the impression that they were reserved for men, like engineering, now you see females working side by side with the men. The same applies to the nursing profession today: Men and women work together for the patient care.

He added:

> I think people understand the role played by the male nurses in our society. However, we have to prove our position in the society by demonstrating skills and knowledge. If we do, then men will be accepted in society; nowadays, there are many male nurses worldwide, and they are acceptable. In Pakistan we have less of

> a concept of males in nursing, but gradually the society will appreciate male nurses.

Thus, encouraging males to become nurses may have a positive impact on the nursing profession because it may change society's views of nursing and nurses.

Research Question 6

The responses of the students and nursing faculty members to Research Question 6, "What are students' views on clinical teaching in Pakistan?" have been integrated into the above questions to provide a holistic picture of the situation.

Limitations of the Study

This study is a component of the PhD program that had to be completed within a given timeframe. The time allocated for the data collection was four months. I collected the data from one private and two government hospitals in Sindh, Pakistan. Because of budgetary and time issues, I could not involve other hospitals in different provinces of Pakistan (Punjab, the Northwest Frontier Province [NWFP], and Baluchistan) in the study. Given more time and resources, I might have been able to undertake a comparative study to explore the understandings of clinical teaching in Pakistan and Canada. This would have provided a new perspective on the topic from a broader framework, considering the two diverse groups of participants.

Clinical teaching involves a number of other health team members in the process, but because of time constrains, I was able to include only clinical nurse teachers and nursing students in this study. However, I later realized during the analysis that because in the government institutions staff nurses do the clinical teaching, it would have been significant to include the staff nurses in the study to gain a holistic understanding of clinical teaching particularly in the government institutions in Pakistan. However, the participants did provide information on the staff nurses whenever it was pertinent in the interview process. For example, when asked about the characteristics of the clinical teachers this question was automatically transformed and responded considering the characteristics of staff nurses. Thus, the information was obtained about the staff nurses by the participants but their views on the topic were not heard.

I collected the data through semistructured interviews and did not consider other sources of data collection such as observations and questionnaires. Follow-up studies could consider these other tools. The influence of professionals in other disciplines (pharmacists, dietitians, clinical administrators, and medical teams) on clinical teaching could be studied by using different research methodologies.

Challenges in Implementing the Suggestions

The research process will not be completed until I have disseminated the research findings. The analysis process made me think of a number of suggestions that I will also want to disseminate. Knowing my working environment (i.e., Pakistan) as I do, I am not sure how these suggestions will be accepted in the nursing education system for many reasons. What I foresee is a sense of insecurity among nursing leaders in adopting the changes/recommendations because of the critical factor of limited knowledge about the research process, which leads to a lack of confidence in supporting scientific information. Another factor is the language barrier: Many nurses in Pakistan have no command over the English language. Thus it is important to consider the following steps.

The first step will be to approach the Pakistan Nursing Council (PNC), which is located in Islamabad, to share the study findings and gain the trust and support of nursing leaders. These presentations will be bilingual to allow nurse leaders to provide their input in Urdu. From this forum, strategies can be planned to implement the recommendations. I hope that having PNC support will accelerate the dissemination of the findings and assist in making appropriate changes in nursing school curricula.

During the presentations I plan to seek input from the hospitals because they are the key players in providing clinical experience to nursing students in the government sector. It is important to consider each step in the process and to reflect on the consequences of the outcomes. Thus, it is extremely important to create awareness of the role of clinical teachers in the country, whether they are staff nurses, classroom teachers, or preceptors at this time.

In this process of change involving the private institution is essential for support and guidance. Keeping all of these factors in mind, planning the time from the research activities assigned to each faculty will be utilized for implementing the recommendations of the study. During the process of implementation, I will keep my co-supervisors from the University of Alberta informed about the changes through e-mail. This is a unique study that will not be completed until the recommendations have been fully implemented practically in Pakistan.

Two Emerging Priorities

In considering all of the issues in clinical education that have emerged from the data analysis of this study, it is apparent that change is needed. I have identified 15 topics for research; the critical need for research on these topics is evident from the data analysis. In this section I will describe these topics and discuss my reasons for selecting them. I propose that the following two issues be addressed first. The participants' first concern was the need for clinical teachers, which requires the development of a role and job description for schools in the government sector. The proposal must be approved at the PNC meeting, and the following questions must be considered: Who is the clinical teacher: a classroom teacher, a staff nurse, or a preceptor? How will he/she be selected? Will the selection be based on knowledge, experience, or both? Is any prior preparation required to be a clinical teacher? Figure 2 depicts the preparation of a clinical teacher.

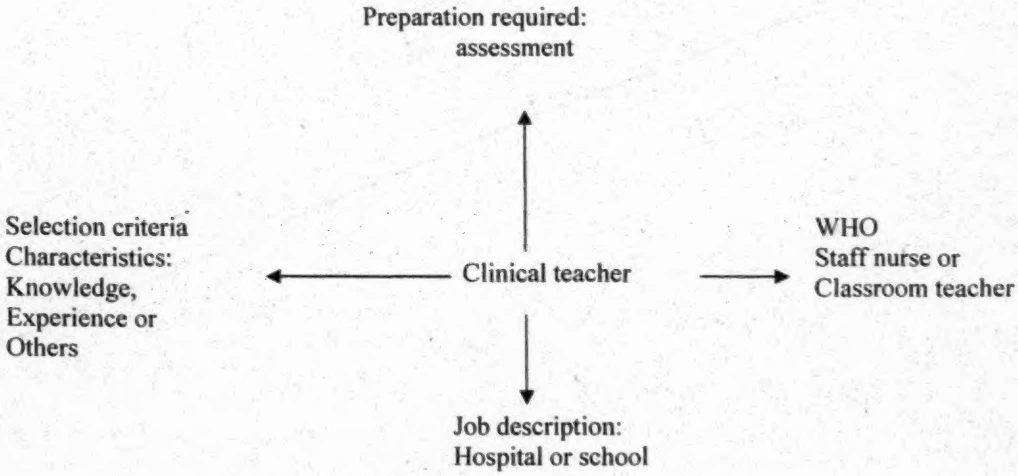
Preparation required:
assessment
Selection criteria
Characteristics:
Knowledge,
Experience or
Others
Clinical teacher
WHO
Staff nurse or
Classroom teacher
Job description:
Hospital or school

Figure 2. The preparation of a clinical teacher.

I hope that having a clinical teacher in the clinical area will enhance students' practical knowledge. This is a challenging task to undertake, and the results will not likely be evident instantaneously. However, the task is huge and requires the input and support of the nursing staff. Private institutions play a major role in advocating for and facilitating the use of clinical teachers in other schools of nursing.

Clinical teaching is a complex phenomenon that involves a number of personnel. The critical ones at this phase are the classroom teacher, staff nurse, and nursing student. More data are required before the administration can be discussed. The data collected reflect the process of clinical teaching in general. Figure 3 illustrates the implications for each component.

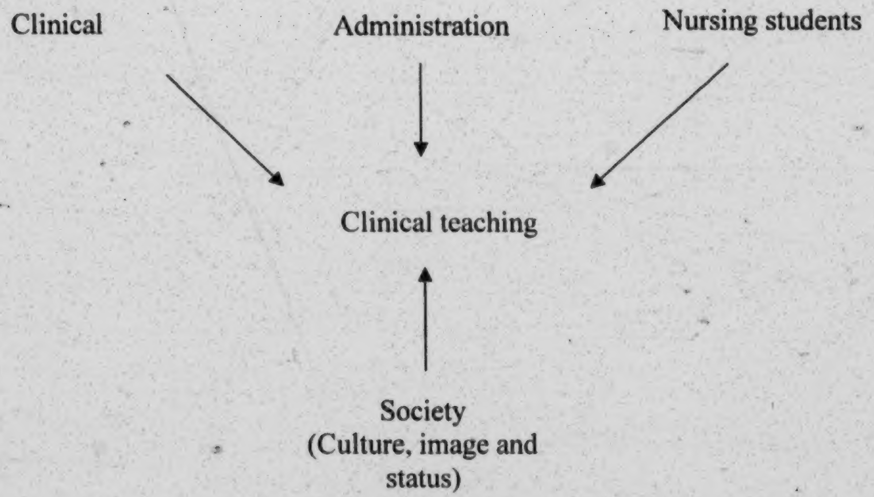
Clinical
Administration
Nursing students
Clinical teaching
Society
(Culture, image and
status)

Figure 3. Factors influencing clinical teaching.

The other priority is clinical evaluation. Evaluations have been challenging for clinical teachers/staff nurses to conduct and difficult for nursing students to accept in a constructive manner. Figure 4 shows the procedures and implications of evaluation.

I have selected these two priorities based on my understanding from working in both the private and government sector. Plans to address the two priorities are flexible, based on the input from the nursing leaders in Pakistan. Figure 4 provides information on the clinical evaluation process.

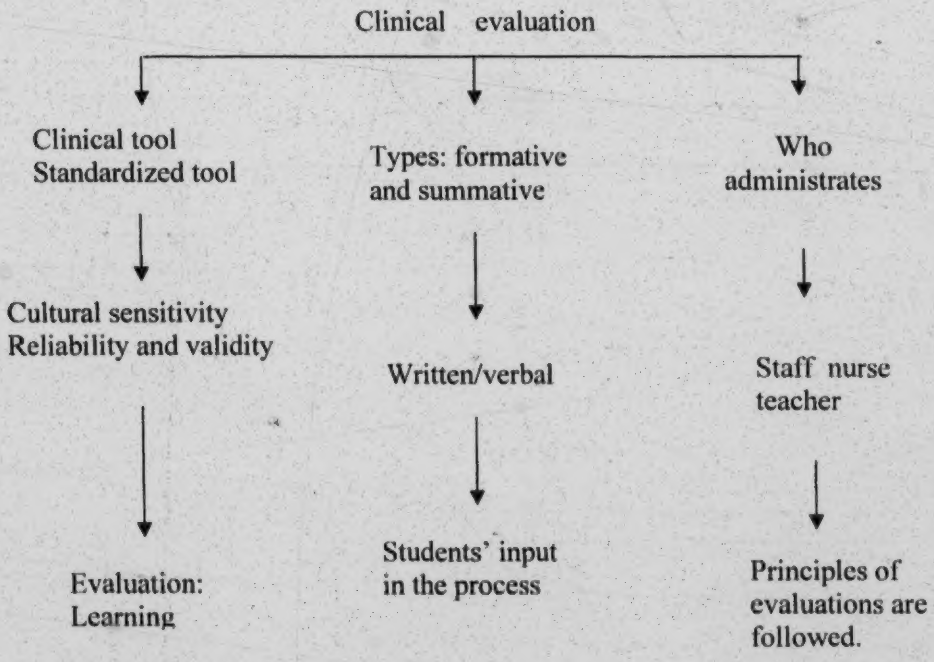
Clinical evaluation
Clinical tool
Standardized tool
Types: formative and summative
Who administrates
Cultural sensitivity
Reliability and validity
Written/verbal
Staff nurse teacher
Evaluation: Learning
Students' input in the process
Principles of evaluations are followed.

Figure 4. The procedures and implications of evaluation.

Implications of the Study for Nursing

This study is the first of its nature to be conducted in Pakistan that explored the concept of clinical teaching in nursing. I hope that the study results will have a positive influence on the profession of nursing. Nursing students, clinical nurse teachers, administrators (policy makers), and patients are the key people affected by the research study outcomes.

Nursing Education

The results of the study reveal the need for clinical teachers, especially in the government sector, which requires developing a program to prepare nurse educators to work in the clinical area. However, because of the shortage of nurses in the country, it may be necessary to examine other models of clinical teaching such as the preceptorship model.

As stated earlier I plan to share the study results with the Pakistan Nursing Council (PNC) in Islamabad to provide information about the existing nursing practices and suggest changes that could be incorporated by the PNC's curriculum committees. Because the PNC is the regulatory body and has the right to make policy changes, it is important that I inform the council about my recommendations. The second step in the process of dissemination is presenting the study findings in the different schools of nursing in the province of Sindh as well as in other regions. This would all be done in collaboration with the PNC and Pakistan Nursing Federal.

The implementation of the findings of this study may result in nurses' being prepared with better skills and knowledge to deal with the challenges of the changing society. This can be achieved only through effective teaching strategies to enhance students' learning and make it a memorable learning experience.

Reflecting on the data, I feel that it is important to examine the role of class teacher, staff nurse, and clinical teacher in the government sector. This means looking at the job expectations, qualifications and experience. The other area to explore is the role of nursing students. In some of the schools of nursing, students are still used as the work force in the service sector. This requires modification. Students are in the learning phase, and it is the responsibility of the institution to provide learning opportunities.

I hope that this study will bring to the forefront some strategies that clinical teachers can adopt when they are working under the constraints of limited resources (financial, human, and material) to meet the objectives of nursing programs. Through the dissemination of the findings will take time. I hope to change the negative image and status of nurses in the country by encouraging nurses to demonstrate professional behavior. This may result in increased enrollment of students in nursing from the remote areas of Pakistan where nursing is not considered a suitable profession for young females.

Nursing Administration

All the recommendations of this study will need the support of nursing administrators. The research data revealed some important aspects of nursing education with regard to workload and type of clinical assignment. It is important to explore these factors if clinical teaching is to be effective.

The teacher-student ratio is high (1:13 in the private institution and 1:25 in the government institutions), but understanding the needs and requirements of nurses, it may not be advisable to reduce the enrolment of students. Nursing leaders and organizations need to develop a strategic plan to resolve this issue.

One barrier to clinical teaching that the participants identified was the lack of resources. It is important that nursing leaders submit proposals for funding (nationally or internationally). Nursing educators require ongoing continuing education to stay up to date on recent changes in nursing education. It is important that nursing administrators expect nursing educators to be responsible for their own continuing education and that they help them with it.

Nursing Research

An awareness of and appreciation for nursing research is growing among nurses in Pakistan, and they are now enrolling in further studies at both the master's and the PhD level, which requires having research knowledge.

An understanding of the process of clinical teaching can be facilitated by using different research approaches. Some of the following topics might be studied:

1. the role of the nurse educator, staff nurse, and classroom teacher in clinical teaching
2. the preparation required to be a clinical teacher
3. the characteristics of clinical teachers compared with those identified in the Western literature
4. the work of Benner to determine how new nursing graduates can progress from novice to expert nurse.
5. alternative models of clinical teaching, such as the Trio model
6. men in nursing in Pakistan
7. the concept of written assignments in clinical teaching (the types and number of assignments per clinical course)
8. the nursing curriculum (clinical hours)
9. learning outcomes of nursing students from the pre and post conferences
10. the clinical evaluation process

11. the role of clinical placements in students' learning
12. the roles of clinical coordinator and clinical nurse
13. the stressors of the clinical teacher in the government and private sectors
14. the stressors of nursing students
15. the role of culture in nursing

This chapter summarizes the findings from the six research questions that I asked of nursing faculty members and nursing students. The challenges in implementing the recommendations are highlighted. Because of the cultural orientation, I selected two priority recommendations to be considered for implementation. I have also discussed the implications of the study for nursing education, administration, and nursing research.

Reflections: The Importance of Context for the Development of Nursing Education in Pakistan

This research study is unique in its own way in that it is the first study to be conducted on this topic in Pakistan. The nursing profession progresses at different rates, depending on the demographics of the country. The context of the country is important to consider, especially with regard to the development of nursing. Nursing in Pakistan has been influenced by various sociopolitical factors. The impact of religion on the nursing profession in Pakistan is another area for further study.

Clinical teaching is a complex process. During their program nursing students learn and develop the practical skills and psychosocial skills to become competent nurses. The three key players in this process are the clinical teacher, the student, and the staff nurse. In the government institutions staff nurses supervise the nursing students during their clinical experience, whereas in private institutions the clinical teacher is responsible for ensuring that students achieve their clinical objectives.

In this new century nurses are expected to work in a global market, which requires fulfilling diverse roles to meet the health care needs of communities. One wonders whether the current nurse educators/staff nurses are teaching those critical skills to future nurses?

The current study was broad in its nature in that I explored various issues in clinical teaching in Pakistan while keeping in mind the cultural values of the country. I have attempted to provide direction to nurse leaders in working on the topics that I have identified in a scientific manner. To progress in Pakistan, nurses need strong leaders who are determined to bring about positive changes in the nursing profession.

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APPENDIX A:

A SUMMARY OF THE SAMPLING

Appendix A: A Summary of the Sampling

Year	Participants	Private institution (1)	Government institution (a)	Government institution (b)
Year I	Students	5	2	3
Year II	Students	5	2	3
Year III	Students	5	2	3
Total	**Students**	**15**	**6**	**9**
Year I	Teachers	5	2	3
Year II	Teachers	5	2	3
Year III	Teachers	5	2	3
Total	**Teachers**	**15**	**6**	**9**
Grand total	**Students and teachers**	**30**	**12**	**18**

APPENDIX B:

INFORMATION LETTER: ENGLISH AND URDU

Appendix B: Information Letter: English and Urdu

Clinical Teaching in Pakistan: The Hard Reality of Nursing Education

Information Letter for Clinical Teachers

Investigator:
Fauziya Ali, Sumar , PhD Candidate,
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PURPOSE OF THE STUDY

I have worked as a clinical teacher in Pakistan for twelve years and I am interested in exploring how clinical nurse teachers and nursing students view clinical nursing education in this country. So far, no research has been conducted in Pakistan on this topic. It is hoped that the information shared by participants will help us better understand clinical teaching in Pakistan.

PROCESS

If you agree to participate I will interview you about your views on clinical nursing education for a period of 45 to 60 minutes. The interview will be audio taped. The interview will take place at a time and location of your choice. A few days after the interview I will ask you to review the interview transcript to ensure that you agree about the content of the transcript. This should take approximately 45 minutes.

RISKS/BENEFITS

There are no known risks to participating in this study. However, at any time if you need to take a break you can tell me and we will stop the interview. In very unlikely event that you become upset during the interview, I will stop interviewing you and provide you with the opportunity to see a counsellor if you wish.

There are no direct benefits for you in participating in this study. However, it may be that the information you provide will help us better understand nursing clinical education in Pakistan and in the long term bring positive changes that will enhance students learning.

CONFIDENTIALITY

Anonymity of the participants will be maintained by using special codes instead of names. Anonymity of institution will be maintained as much as possible; all efforts will be taken to ensure that readers cannot recognize the participants and the institution.

A code will be used to identify participants. Details of that code will be known by the researcher and co-supervisors. The interviews will also be transcribed using a fictional name instead of your own name. The person who transcribes the interviews will also follow the principles of confidentiality.

The audiotapes will be stored in a locked cabinet for a minimum of five years. Some of the things said in the interview may be quoted in the text of the thesis, however, the identity of participants will not be revealed. The supervisors of the researcher will also have access to the data.

A study report will be written and findings will be disseminated through publications in academic journals, workshops, and conferences. Your name will not appear in these publications.

CONSENT AND FREEDOM TO PARTICIPATE

Participation in this study is entirely voluntary. You may consent in writing or verbally tape recorded. You may refuse to answer any question in the interview. Participants may, at any time, withdraw from the study. There is no penalty for withdrawing. Participation in this study will not affect the conditions of your employment. The results of this research will be given to participants if they wish to have them.

There is a possibility that the data from this study may be useful for future studies. If data is used for a secondary analysis after this study is completed, the study would undergo an ethics review to ensure the ethical principles are followed and the rights of the participants are ensured.

CONTACTS

If you have any questions about this research, please contact Fauziya Ali, Sumar at 4930051 or my co-supervisors Dr Day or Dr Paul.

If you have any concerns about this study you may contact Dr. Yasmin Amarsi, Dean of the School of Nursing, Aga Khan University at 49346876.

Clinical Teaching in Pakistan: The Hard Reality of Nursing Education

Information Letter for Nursing Students

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PURPOSE OF THE STUDY

I have worked as a clinical teacher in Pakistan for twelve years and I am interested in exploring how clinical nurse teachers and nursing students view clinical nursing education in this country. So far, no research has been conducted in Pakistan on this topic. It is hoped that the information shared by participants will help us better understand clinical teaching in Pakistan.

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A study report will be written and findings will be disseminated through publications in academic journals, workshops, and conferences. Your name will not appear in these publications.

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If you have any concerns about this study you may contact Dr. Yasmin Amarsi, Dean of the School of Nursing, Aga Khan University at 49346876.

معلوماتی فہرست

اسٹڈی کا مقصد

میں پاکستان م، یں بارہ سال سے کلینکل ٹیم کی حیثیت سے کام کررہی ہوں۔ اور میں جاننا چاہتی ہوں کہ میرے مُلک مین کلینکل نرس ٹیچر اور نرسنگ اسٹوڈنٹ کا کیا طریقہ کار ہے۔ اب تک اس موضوع پر پاکستان میں کسی نے بھی تحقیق نہیں کی ہے۔ اور اُمید کرتی ہوں کہ جو معلومات اس موضوع میں حصہ لینے والے شرکاء کے درمیان ہوگی اس سے ہمیں پاکستان میں کلینکل ٹیچنگ کو سمجھنے میں بہت مدد ملے گی۔

طریقہ کار۔

اگر آپ اس پروگرام میں شرکت لینا چاہیں تو اس کے لئے ہم آپ کا انٹرویو لینگے۔ جس میں آپ کلینکل نرسنگ کی تعلیم کے بارے میں اپنے خیالات کا اظہار کرلینگے انٹرویو کا دورنیہ 45 سے 60 منٹ ہوگا۔ اور انٹرویو آڈیو ٹیپ پر ریکارڈ ہوگا۔ انٹرویو کے لئے جگہ اور وقت کا تعین آپ کی مرضی کا ہوگا۔ اور کُچھ دنوں بعد میں آپ کو اس انٹرویو کا ٹرانکرپٹ دونگی تا کہ آپ کی رائے لی جا سکے اور یہ تقریباً 45 منٹ لیگا۔

فائدے / نقصانات

اس اسٹڈی میں حصہ لینے کا کوئی نقصان نہیں مگر پھر بھی اگر دورانِ انٹرویو آپ منقطع کرنا چاہیں تو ہم انٹرویو روک سکتے ہیں اور ایسا بھی ہو سکتا ہے کہ آپ انٹرویو کے دوران اگر کوئی بات آپ کو بے چین کرے تو میں انٹرویو روک دونگی اور آپ کو اس کا حق ہوگا کہ آپ چاہیں تو کونسلر سے رجوع کرسکتے ہیں۔

اور اسی طرح اس اسٹڈی کا فائدہ یوں ہے کہ جو معلومات ہم آپ سے لینگے وہ نرسنگ کلینکل ایجوکیشن پاکستان میں آنے والے وقت میں اس کے معیار کو بہتر بنایا جاسکتا ہے۔

راڑداں

اس بات کا خاص خیال رکھا جایٔگا کہ حصہ لینے والے شرکاء کے نام کے بجائے کوڈ استعمال کیا جائے گا اور اسی طرح انسٹیوٹ کا نام بھی پوشیدہ دکھا جایٔگا۔ تا کہ پڑھنے والے کو حصہ لینے والے اور انسٹیو ٹیوٹ کا پتہ نہ چلے اور ان کو کسی تفصیل کا پتہ ریسرچ اور کو سُپر وائزر کو ہوگا اور انٹرویو کو جب ڈانسکر پٹ دیا جایٔگا تو اس میں انکے نام فرضی ہونگے ۔ اور جو بھی انٹرویو پر عمل کرنا واجب ہوگا۔ آڈیو ٹیپ کو لاکر مین بحفاظت پانچ سال کے لئے رکھ دیا جائے گا۔ اس انٹرویو کی کچھ باتیں ہم اپنے کیس میں بھی ریفر کرینگے۔ مگر اس میں بھی حصہ لینے والے کو پوشیدہ رکھا جائے گا۔ صرف رِچر اور سُپر وائزر کو اس کے حصول کی اجازت ہوگی۔ اس اسٹڈی رپورٹ کی لکھت اور اشاعت ایکیڈ مک جرتاتر، ورک شائز اور کانفرنس میں شائع کیا جایٔگا۔

اجازت نامہ۔

اس اسٹڈی میں شرکت بالکل رضا کارانہ ہوگی اور آپ کو اس کا حق حاصل ہوگا کہ کسی بھی سوال کے جواب کو دینے سے انکار کر سکتے ہیں اور اس بات کا بھی حق ہوگا کہ وہ اس اسٹڈی سے جب چاہے اپنے آپ کو الگ کر سکتے ہیں اور اس کے لیے اس کو کوئی حرجانہ ادا کرنے کی ضرورت نہیں ہوگی۔

اور اگر شرکت کرنے والا اس ریسرچ کے نتائج حاصل کرنا چاہتا ہے تو اسکو اسکی کاپی مل سکتی ہے۔

رابطہ۔

اور اگر اس ریسرچ کے متعلق آپ کو کوئی سوال پوچھنا ہو تو اس کے لئے برائے مہربانی

فوزیہ علی سُمار 9221-4930051

ڈاکٹر ڈے / ڈاکٹر پال سے رابطہ کریں۔

اور اس اسٹڈی کے متعلق کوئی شک وشعبہ ہو تو آپ ڈاکٹر یاسمین امرسی (ڈین آف اسکول آف نرسنگ، آغا خان آغا خان یونیورسٹی

9221-49346876 سے رجوع کریں

تاریخ------------------------ دستخط------------------------

APPENDIX C:

CONSENT FORM: ENGLISH AND URDU

کنیکل ٹیچنگ ان پاکستان نرسنگ ایجوکیشن کی تلخ حقیقت

مضمون:	اجازت نامہ
حصہ الف:	ریسرچز کا تعارف
پرنسیپل انوسٹیگیٹر	فوزیہ علی سُمار پی ایچ ڈی اسٹوڈنٹ یونیوسٹی آف البرٹا
کانٹیکٹ انورمیشن	fsumar@ualberta.ca
پاکستان کا فون نمبر	611-9221-4930051
ایڈمنٹن کا فون نمبر	780-485-1503

نام تعلق اور معلومات برائے کوانوسٹیگیٹر اسپر وائزر

ڈاکٹر دین ڑے

پروخیر ایسوسیٹ ڈین

ایگزیکٹیو پاٹنرشپ ڈیویلپمنٹ

فیکلٹی آف نرسنگ، یونیورسٹی آف البرٹا

rene.day@ualberta.ca

ٹیلی فون نمبر 780-492-6481

ڈاکٹر پولین پول

ایسوسیٹ پروفیسر اور ایسوسیٹ ڈین ایکیڈمک پلانگ پروگرام

فیکلٹی آف نرسنگ یونیورسٹی آف البرٹا

pauline.paul@ualberta.ca فون نمبر 780-7479

حصہ (ب) اجازت نامہ

	ہاں	ناں
۔ کیا آپ کو ریسرچ اسٹڈی میں شامل ہونے کے لئے پوچھا گیا ہے؟		
۔ کیا آپ نے انفورمیشن شیٹ کو پڑھا اور وصول کیا ہے؟		
۔ کیا آپ اس ریسرچ اسٹڈی کے فوائد اور نقصانات سے باخبر ہیں؟		
۔ کیا آپ کو اس اسٹڈی کے بارے میں سوال کرنے کا یا بحث کرنے کا موقع ملا ہے؟		
۔ آپ کو اجازت ہے کہ اسٹڈی میں شامل ہونے سے انکار کر سکتے ہیں؟ اور اس کے لئے آپ کو کوئی وجہ بیان کرنے کی ضرورت نہیں ہے۔		
۔ کیا تم اسکی کونفڑنشیائی / بوشیدہ راز کے بارے میں بتایا گیا ہے؟ اور کیا تم کو معلوم ہے کہ ریسرچ ڈیٹا کون حاصل کر سکتا ہے؟		

حصہ: ج دستخط

مندرجہ بالا اسٹڈی مجھے بتائی گئی تھی۔

تاریخ:-----------------

میں اس اسٹڈی میں شرکت کے لئے رضامند ہوں

ریسرچ پارٹیسمینٹ کے دستخط

نام:-----------------

گواہ (اگر موجود ہوں) ---------------------------------------

نام--

میں سمجھتی ہوں کہ اس فارم کو دستخت کرنے وال اس اسٹڈی میں رضا کارانہ طور پر شامل ہونا چاہتا ہے:

ریسرچر ------------------------

نام ------------------------

Appendix C: Consent Form: English and Urdu

Clinical Teaching in Pakistan: The Hard Reality for Nursing Education

Title of Project: Clinical Teaching in Pakistan: The Hard Reality for Nursing Education **Part 1: Researcher Information**
Name of Principal Investigator: Fauziya Ali, Sumar Affiliation: PhD Candidate, University of Alberta Contact Information: Contact: fsumar@ualberta.ca Phone # in Pakistan: Contact # in Edmonton: 780- 485-1503
Name, Affiliation & Contact Information Co-Investigator/Supervisor: Dr. Pauline Paul Associate Professor & Associate Dean Academic Planning & Programs Faculty of Nursing, University of Alberta pauline.paul@ualberta.ca Telephone number 1 (780) 492-7479 Dr. Rene Day Professor, Associate Dean Executive & Partnership Development. Faculty of Nursing, University of Alberta rene.day@ualberta.ca Telephone number: 1 (780) 492-6481
Part 2: Consent of Subject

	Yes	**No**
Do you understand that you have been asked to be in a research study?		
Have you read and received a copy of the attached information sheet?		
Do you understand the benefits and risks involved in taking part in this research study?		
Have you had an opportunity to ask questions and discuss the study?		
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and it will not affect your care.		
Has the issue of confidentiality been explained to you? Do you understand who will have access to the research data?		

Part 3: Signatures

This study was explained to me by:

Date:

I agree to take part in this study.

Signature of Research Participant:

Printed Name:

Witness (if available):

Printed Name:

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Researcher:

Printed Name:

* A copy of this consent form must be given to the subject.

APPENDIX D:

ETHICS APPROVAL

Health Research Ethics Board

2J2.27 Walter Mackenzie Centre
University of Alberta Edmonton Alberta T6G 2R7
p 780 492 9724
p 780 492 0459
p 780 492 0839
f 780 492 7303
ethics@med.ualberta.ca

HEALTH RESEARCH ETHICS APPROVAL

Date of HREB Meeting: November 5, 2004

Name of Applicant: Dr. Pauline Paul

Organization: University of Alberta

Department: Faculty of Nursing

Project Title: **Clinical teaching in Pakistan: The hard reality for nursing education**

The Health Research Ethics Board (HREB) has reviewed the protocol for this project and found it to be acceptable within the limitations of human experimentation. The HREB has also reviewed and approved the subject information letter and consent form.

The approval for the study as presented is valid for one year. It may be extended following completion of the yearly report form. Any proposed changes to the study must be submitted to the Health Research Ethics Board for approval. Written notification must be sent to the HREB when the project is complete or terminated.

NOV 18 2004

Glenn Griener, PhD.
Chair, Health Research Ethics Board
(B: Health Research)

Date of Approval Release

File number: B-091104

آغا خان یونیورسٹی
THE AGA KHAN UNIVERSITY

Faculty of Health Sciences
Medical College

November 30, 2004

Dr. Fauziya Sumar
School of Nursing
Aga Khan University
Karachi

Dear Ms. Sumar,

Re: 371-SON-ERC-04. PI-Ms. Fauziya Sumar: Clinical teaching in Pakistan: The hard reality for nursing education.

Further to our letter of provisional approval dated November 8, 2004 as a result of an expedited review to your above mentioned study.

The study was reviewed and discussed in our meeting held on November 19, 2004 at Aga Khan University. The Committee had no objection hence the study was given a final approval for a period of one year.

Any changes in the protocol or extension in the period of study should be notified to the Committee for prior approval. All informed consents should be retained for future reference.

Thank you.

Yours sincerely,

Dr. Rumina Hasan
Chairperson
Ethical Review Committee

Stadium Road, P. O. Box 3500, Karachi 74800, Pakistan.
Cable: Akaproject, Telex: [illegible] AKHMC PK, Fax: (92) 21 493-4294, 493-2095, Telephone: 493-0051

APPENDIX E:

ACCESS TO THE PARTICIPANTS

Government and Private Institutions

آغا خان یونیورسٹی
THE AGA KHAN UNIVERSITY

Faculty of Health Sciences
School of Nursing

December 16, 2004

Ms. Fauziya Ali
Assistant Professor, AKU-SON and
PhD student at University of Alberta
Canada

Re:
Subject: Access of research participants:
Research Study Clinical Teaching in Pakistan: The hard reality of Nursing Education

Dear Fauziya,

Thank you for your letter of December 8th on the above subject.

Permission is hereby granted to you to interview 30 participants from AKU-SON to conduct research study as part of your PhD programme requirement.

Sincerely,

Yasmin Amarsi, PhD, RN
The Shakur Jamal Professor and
Dean, School of Nursing
Aga Khan University

Phone No.9204202:

OFFICER OF THE DIRECTOR
DIRECTORATE OF NURSING SINDH
T.H.O.SADDAR TOWN COMPOUND KALAPUL
KARACHI

NO.DNSK/F.V (01)/- 5065/66

Karachi, dated the 8th Dec: 2004.

To,

The Principal (SON)
Civil Hospital,
Karachi.

SUBJECT:- **ACCESS OF RESEARCH PARTICIPANTS:**
CLINICAL TEACHING IN PAKISTAN: THE HARD REALITY OF NURSING EDUCATION.

Ms.Fauziya Ali Assistant Professor and PhD student at University of Alberta Canada intends to conduct a research study as a part of her PhD programme requirements on the Topic mentioned above. The purpose of study is to explore the process of clinical teaching in Pakistan.

The study protocol requires interviewing the nursing faculty and Diploma students of three years 30 participants (Students / Teachers) will be interviewed at civil Hospital Karachi. Each interview will take 40 – 60 minutes and conform to the ethical considerations of the qualitative research protocols.

Please ensure your cooperation and support in this study programme and facility her in all respects.

DIRECTOR
DIRECTORATE OF NURSING
SINDH KARACHI

Copy forwarded for information to:-

1. ✓ Ms.Fauziya Ali Assistant Professor, AKU-SON and PhD student at University of Alberta Canada.

DIRECTOR
DIRECTORATE OF NURSING
SINDH KARACHI

APPENDIX F:

SEMISTRUCTURED INTERVIEW GUIDES

Appendix F: Semistructured Interview Guides

Clinical Teachers

Brief Introduction

- Researcher
- Participant

Broad Questions

1. What is clinical teaching to you?
2. What are the factors that facilitate clinical teaching in Pakistan?

Clinical Philosophy

1. What is your educational philosophy?
2. What is happening in the field of clinical teaching in Pakistan?
3. How would you like to see clinical teaching in Pakistan?

Characteristics

1. What are the characteristics of an effective clinical teacher?
    - Knowledge, skills, humanistic qualities, and others: Specify.

Teaching and Learning Strategies

1. What is innovation in clinical teaching?
2. What strategies do you use as a clinical teacher to enhance students' learning?
3. Do you know of other teaching and learning strategies that are used in the clinical area, but that you do not use?
4. What are your comments on models of clinical teaching?
    - Clinical teacher, preceptor, staff nurses, combination
5. What are your views on written assignments in the clinical area?
    - Nursing care plan, portfolio, case studies, journal writing
6. What are your comments on pre- and postconference?
    - Time, objectives, structure, effectiveness

Stressors

1. What are stressors you face as a clinical teacher?
    - Working environment, expectation from school and service, student ratio, resources
2. What are your views on comfort level in the clinical area?
3. How do you get a sense of being wanted in the clinical area?
4. How do you feel in the clinical area?

5. Do you think prior working experience in the clinical area facilitates students' learning? How?
6. What strategies do you think a clinical teacher needs to implement in the clinical area to be accepted?
7. In your opinion, how do you see the following factors contributing to students learning?
    - Clinical experience, content expertise, support from the services/staff
8. Does clinical teaching make it difficult for you to meet other responsibilities you have in your school?

Placement

1. What are your comments on the current placement sites for the students' clinical experience?

Culture

1. Do you think culture has an influence on nursing in Pakistan?

Challenges

1. What are some of the challenges you face as a clinical teacher in Pakistan?
    - Multiple roles: mother, wife, sister (female)
    - Male administrator: power

Evaluation

1. What strategies do you use to evaluate students' performances in the clinical area?
    - Observation, OSCE, written assignments, evaluations
2. Do you think clinical performance should be graded? Why or why not?

General

1. What are your comments on the theory-practice gap in Pakistan?
2. Do you think there is a need for continuing education sessions for clinical teachers? If yes, on what?

Any comments or suggestions?

Semistructured Interview Guide

Nursing Students

1. What is clinical teaching?
2. How would you like to see clinical teaching in Pakistan?

Characteristic

1. What are your views on the characteristics of an effective clinical teacher?

Teaching and Learning Strategy

1. Do you think pre- and post-conferences are effective in enhancing students' clinical learning?
2. What are your reflections on written assignments in the clinical area, such as nursing care plans, portfolios?

Stressor

1. What are some of the stressors nursing students face in the clinical area?
2. Do you enjoy your clinical experience?
3. In your opinion, do you think clinical teachers' past clinical experience and content expertise contribute to students' learning? How?

Placement

1. What are your comments on the current placement sites for the students' clinical experience?

Culture

1. Do you think culture has an influence on nursing in Pakistan?
    - Cultural norms: male patients, Purdah system

Challenges

1. What are some of the challenges you face as a nursing student in Pakistan?
    - Availability of resources, human (expertise, number)

Evaluation

1. What are your views on clinical evaluation?
2. Do you think clinical performance should be graded? Why or why not?

Any comments/suggestions?